

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06183

CERTIFICATE OF DEATH

06180

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYVILLE, MD d. STREET ADDRESS CADD ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ARUNA A Shepherdson ABELL		4. DATE OF DEATH 5 17 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-5-44
9. AGE (In years last birthday) 23 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (County & State, or foreign country) Baltimore City		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME GEORGE W. Abell of A		14. MOTHER'S MAIDEN NAME CONSTANCE Gill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-42-0919	
17. INFORMANT FATHER - SAME ADDRESS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 493 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 1			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH WEEKS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-4 , 1967, to 5-17 , 1967, that (I) (we) lost the deceased alive on 5-16 - 1967, and that death occurred at 12:16 AM, from causes on and on the date stated above.			
22a. SIGNATURE R Vieta		22b. DATE SIGNED 5-17-67	
22c. PHYSICIAN'S NAME (Type) ROLANDO VIETA		22d. ADDRESS SPRING GROVE STATE HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE THEREOF May-18-67	23c. NAME OF CEMETERY OR CREMATORY GreenMount	23d. LOCATION (City or Town) (County) (State) Baltimore Md. 21202
24. FUNERAL DIRECTOR Stewart & Mowen Co 108-W-North-Av (21201)		25a. REC'D BY REGISTRAR MAY 18 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE J Charles Judge	

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RECEIVED 30 JAN 1961

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

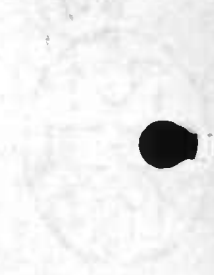
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
06190					06181					
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b <u>11fe</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Balto medical Center</u>					d. STREET ADDRESS <u>3409 White Ave</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Alice</u> First <u>(Estelle)</u> Middle <u>10ELL</u> Last <u>Adams</u>					4. DATE OF DEATH Month <u>MAY</u> Day <u>18</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/29/10</u>		9. AGE (In years last birthday) <u>56</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William Henry Price</u>					14. MOTHER'S MAIDEN NAME <u>Fanny Saunders</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Admission Sheet</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of the lung with Metastasis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH <u>2 Months</u> <u>2 Month</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>5-9</u> , 19 <u>67</u> , to <u>5-18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/17</u> 19 <u>67</u> , and that death occurred at <u>335AM</u> , from the causes and on the date stated above.										
22a. SIGNATURE <u>Derek A. Bruce</u>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>5/18/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>DEREK A. BRUCE</u>					22d. ADDRESS <u>C.B.M.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/22/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>				
24. FUNERAL DIRECTOR ADDRESS <u>Robert C. Altenburg - 6009 Harford Rd.</u> <u>Funeral Home, Inc.</u>					25a. REC'D BY REGISTRAR DATE <u>MAY 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
06191 CERTIFICATE OF DEATH 06182

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Essex, Maryland 21221	
c. LENGTH OF STAY IN 1b 10mth6dys		d. STREET ADDRESS 1644 Eastern Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle M. Last Adams		4. DATE OF DEATH Month May Day 9 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1884
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 03 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) molding		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Joseph Adams		14. MOTHER'S MAIDEN NAME Catherine Scriver	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNK (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 213-01-4135	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis, severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from June 1, 1966 to May 9, 1967 , that (we) last saw the deceased alive on May 9, 1967 , and that death occurred at 11:55 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachsler		22b. DATE SIGNED 5-9-67	
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/12/67	
23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Mem.		23d. LOCATION (City, town or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR J. H. Connelly Sons		25a. REC'D BY REGISTRAR 300 more	
25b. REGISTRAR'S SIGNATURE J. Charles Judge		DATE MAY 12 1967	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN 1b Hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. JOSEPH HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON	
3. NAME OF DECEASED (Type or print) VIRGINIA Denmead AITEN		4. DATE OF DEATH Month MAY Day 31 Year 19 67	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-1-85
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Partner		10b. KIND OF BUSINESS OR INDUSTRY Master Tile Co.	9. AGE (In years last birthday) yrs. 81
11. BIRTHPLACE (State or foreign country) Baltimore, Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joshua T. Kelley		14. MOTHER'S MAIDEN NAME May Parks	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-30-5144	
17. INFORMANT Mrs. Virginia D. Ruley		Address 238 Burke Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22. DATE SIGNED 5-31-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/3/67	
23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204		25a. REC'D BY REGISTRAR JUN 5 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
06193 CERTIFICATE OF DEATH 05184

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton - Rural</u>				c. LENGTH OF STAY IN 1b <u>6.8 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Mt Carmel Road</u>				e. STREET ADDRESS <u>Mt Carmel Road</u>			
3. NAME OF DECEASED (Type or print) <u>Florence Virginia ALBAN</u>				4. DATE OF DEATH <u>May 18 1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-23 1890</u>	
9. AGE (In years, last birthday) <u>76 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Freeland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John McCann</u>				14. MOTHER'S MAIDEN NAME <u>Virginia AYRES</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>218-22-4992</u>		17. INFORMANT <u>Mrs Mary Ruth Withelman</u> Address <u>Parkton Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-17</u> , 19 <u>67</u> , to <u>5-18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-18</u> , 19 <u>67</u> , and that death occurred at <u>20</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph E. Bush</u>				22b. DATE SIGNED <u>5/18/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>				22d. ADDRESS <u>HAMPSTEAD Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5/21/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PINEGROVE</u>		23d. LOCATION (City, town or county) (State) <u>Parkton, MD.</u>	
24. FUNERAL DIRECTOR <u>John E. Goff</u>				25a. REC'D BY REGISTRAR <u>HAMPSTEAD, MD.</u>		25b. REGISTRAR'S SIGNATURE <u>John E. Goff</u>	
				DATE <u>MAY 23 1967</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06194

CERTIFICATE OF DEATH

07661

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 23yr2mth6dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 2101 Cold Spring Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles (Kratz) Alexander			4. DATE OF DEATH Month May Day 22 Year 19 67				
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1896		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) guard		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John Kratz			14. MOTHER'S MAIDEN NAME Margaret Helwig				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 217-03-6680		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyelonephritis with uremia 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerotic cardiovascular disease DUE TO (c) Generalized arteriosclerosis, severe						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (X) (this hospital) attended the deceased from March 13, 19 64 to May 22, 19 67 , that (I) we last saw the deceased alive on May 22, 19 67 , and that death occurred at 2:45 M, from causes and on the date stated above.							
22a. SIGNATURE Stella Wachslar			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-22-67		
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.			22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF May 26, 1967	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Frank J. Hall, Pikesville, Md.			ADDRESS		25a. REC'D BY REGISTRAR JUN 7 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06195

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06185

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL LOCHearn</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL LOCHearn</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6417 LIBERTY Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>C.</u> Last <u>ALLEN</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>10</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 25, 1905</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>10</u> Hours <u>10</u> Min.	IF UNDER 24 HRS. Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll County MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>William ARBAUGH</u>			
14. MOTHER'S MAIDEN NAME <u>ANN WILHIDE</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. <u>220-48-2402</u>				17. INFORMANT <u>Husband</u> Address <u>MR. GEORGE ALLEN 6417 LIBERTY RD BALTIMORE 21207 MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF BREAST & Metastases</u> 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 10, 1954</u> to <u>MAY 10, 1967</u> , that (I) (we) last saw the deceased alive on <u>MAY 10, 1967</u> , and that death occurred at <u>5:20 PM</u> , from the causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. SIGNATURE <u>Edwin L. Pierpont</u>				22b. DATE SIGNED <u>5/10/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT, M.D.</u>				22d. ADDRESS <u>8204 LIBERTY RD - BALTIMORE 21207 MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>5/13/67</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery-</u>				23d. LOCATION (City, town or county) (State) <u>Baltimore, Md. 21207</u>			
24. FUNERAL DIRECTOR <u>Loring Byers-8728 Liberty Rd. Randallstown</u>				25a. REC'D BY REGISTRAR <u>MAY 15 1967</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06196

CERTIFICATE OF DEATH

06186

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY in 1b 135 DAYS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				e. STREET ADDRESS 1420 SOUTH CHARLES STREET			
3. NAME OF DECEASED (Type or print) First JACK Middle PHILLIP Last AMBROSE				4. DATE OF DEATH Month MAY Day 20 Year 1967			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10/6/19		9. AGE (In years last birthday) yrs. 47	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIREMAN		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (County & State, or foreign country) FREDERICK, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID L. AMBROSE				14. MOTHER'S MAIDEN NAME MARY PHILLIPS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. 214 14 17 78		17. INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA WITH METASTASIS 1621 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH ONE MONTH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the this hospital attended the deceased from JAN 5 , 1967, to MAY 20 , 1967, that we (we) last saw the deceased alive on MAY 20 , 1967, and that death occurred at 8:10 PM , from causes on and on the date stated above.							
22a. SIGNATURE <i>Peter V. Juvan</i>				22b. DATE SIGNED 5/20/67		22c. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/24/67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY BALTIMORE, MARYLAND		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR CHAS. L. STEVENS FUNERAL HOME BALTO., MD.				25a. REC'D BY REGISTRAR MAY 23 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06197

CERTIFICATE OF DEATH

06187

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 30.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		d. STREET ADDRESS 1711 Wilkens Avenue	
3. NAME OF DECEASED (Type or print) First Bertha Middle A. Last Appler		4. DATE OF DEATH Month MAY Day 6 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 8-19-93
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Adolph		14. MOTHER'S MAIDEN NAME Marie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Records: Spring Grove State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Pneumonia DUE TO (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) none		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from April 20, 1967 , to 5/6 , 1967, that (X) (we) last saw the deceased alive on 5/6 , 1967, and that death occurred at 2:25 AM , from causes and on the date stated above.			
22a. SIGNATURE Narciso W. Charnona M.D.		22b. DATE SIGNED MAY 8 1967	
22c. PHYSICIAN'S NAME (Type) NARCISO W. CHARNONA		22d. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/9/67	
23c. NAME OF CEMETERY OR CREMATORY London Park		23d. LOCATION (City or Town) (County) (State) Baltimore Md	
24. FUNERAL DIRECTOR Witzke F.H. Baeto Md.		25a. REC'D BY REGISTRAR MAY 8 1967	
25b. REGISTRAR'S SIGNATURE James Jones		DATE	

06187

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REPORT OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
06198
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Woodlawn</u> c. LENGTH OF STAY IN 1b <u>2 Years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2121 GWYNN OAK AVE</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - WOODLAWN</u> d. STREET ADDRESS <u>3800 WINDSOR MILLS</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>ERNEST</u> Last <u>ARMACOST</u>		4. DATE OF DEATH Month <u>5</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/15/1910</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARBER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BARBER</u>	11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>
13. FATHER'S NAME <u>JOHN E. ARMACOST</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-05-4839</u>	
17. INFORMANT <u>MARGARET ARMACOST</u>		Address <u>BALTO 21207 MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA & METASTASES (OF RECTUM)</u> 154X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ (c) _____ DUE TO DUE TO DUE TO INTERVAL BETWEEN ONSET AND DEATH <u>4 YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>OCT 15, 1933</u> to <u>MAY 2, 1967</u> , that (I) (we) last saw the deceased alive on <u>APRIL 30, 1967</u> , and that death occurred at <u>HOME</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Edwin E. Pierpont</u>		22b. DATE SIGNED <u>5/2/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWIN E. PIERPONT, M.D.</u>		22d. ADDRESS <u>8204 LIBERTY RD. BALTO 21207 MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5-5-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	23d. LOCATION (City, town or county) <u>Baltimore, MD</u> (State) _____
24. FUNERAL DIRECTOR <u>Ellsworth Armacost</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
ADDRESS <u>4600 Liberty Heights Ave</u>		DATE <u>MAY 3 1967</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 23b, file #389 5/29/67 kk

06199

CERTIFICATE OF DEATH

06189

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				e. STREET ADDRESS 770 W. SARATOGA STREET, APT 203			
3. NAME OF DECEASED (Type or print) First MARVIS Middle A. Last ARMSTRONG				4. DATE OF DEATH Month MAY Day 16 Year 19 67			
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 13, 1932		9. AGE (In years last birthday) yrs. 35	10. IF UNDER 1 YEAR Months Oys Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSING ASSISTANT			10b. KIND OF BUSINESS OR INDUSTRY HOSPITAL		11. BIRTHPLACE (County & State, or foreign country) GREENVILLE, N. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JESSIE ALLEN				14. MOTHER'S MAIDEN NAME ROSETTA DICKSON			
15. WAS DECEASED EVER IN U.S. ARMOED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. 219 34 67 77		17. INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMOLYTIC CRISIS 2926 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) SICKLE CELL ANEMIA DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from 5/14/67 , 19__, to 5/16/67 , 19__, that (s) (we) last saw the deceased alive on 5/16/67 , 19__, and that death occurred at 12:10 PM from causes and on the date stated above.							
22a. SIGNATURE George Dudas, M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/16/67	
22c. PHYSICIAN'S NAME (Type) GEORGE DUDAS, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/20/67		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEMORIAL CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.	
24. FUNERAL DIRECTOR 1727 N. Monroe St.				ADDRESS PHILLIPS FUNERAL HOME		25a. REC'D BY REGISTRAR DATE MAY 22 1967	
						25b. REGISTRAR'S SIGNATURE Charles J. J...	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
06200						06190					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <u>Balto.</u> MARYLAND						a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>					
c. LENGTH OF STAY IN 1b <u>14 days</u>						d. STREET ADDRESS <u>5509 Gwynn Oak Ave</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>G.B.M.C.</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
			<u>Arthur NNN Arnold</u>			<u>5</u> <u>11</u> <u>19 67</u>					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
<u>M</u>		<u>W</u>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<u>2-15-75</u>		<u>92</u> yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Co. Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Wm. Samuel Arnold</u>				14. MOTHER'S MAIDEN NAME <u>Younger, Anna</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNK</u>				16. SOCIAL SECURITY NO. <u>218-18-0833-J1</u>				17. INFORMANT <u>Raymond A. Arnold</u> Address <u>600 Coventry Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4221 Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Semility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>4-26</u> , 19 <u>67</u> , to <u>5-11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-10</u> , 19 <u>67</u> , and that death occurred at <u>1:20</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>Manuel A. Gongon</u>						ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>MANUEL A. GONGON</u>						22b. DATE SIGNED <u>5-11-67</u>					
22d. ADDRESS <u>GBMC-TOWSON, MD.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>May 13, 1967</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Hereford Bap. Ch. Cemt Hereford, Md.</u>			
23d. LOCATION (City, town or county) (State) <u>Catonsville, Md.</u>				23e. REC'D BY REGISTRAR <u>MAY 15 1967</u>				23f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06201

06191

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>		c. LENGTH OF STAY IN 1b <u>2 Yrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Halethorpe 031</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4714 Washington Blvd.</u>				d. STREET ADDRESS <u>4714 Washington Blvd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Renée</u> Middle <u>Arthur</u> Last <u></u>				4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/9/82</u>	9. AGE (in years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George R. Hayden</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Hixson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-54-4146</u>		17. INFORMANT <u>Mary H. Greff</u> Address <u>4714 Washington Blvd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular disease</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>complications of age</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Totally blind for 5 yrs</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>67</u> , to <u>May 1</u> , 19 <u>67</u> , that (I) (<u>was</u>) last saw the deceased alive on <u>Apr 29</u> , 19 <u>67</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Dr. Bruce B. Brumbaugh</u>				22b. DATE SIGNED <u>May 1/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. Bruce B. Brumbaugh</u>	
22d. ADDRESS <u>5609 Main St. Elkridge</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/2/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Dorsey Maryland</u>	
24. FUNERAL DIRECTOR <u>Amber Inc. 1329 Sulphur Sp. Rd</u>				25a. REC'D BY REGISTRAR <u>MAY 4 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

08130

08130

MAY 1 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06202

CERTIFICATE OF DEATH

06192

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. LENGTH OF STAY IN 1b <u>6 YEARS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ARMACOST NURSING HOME</u>		d. STREET ADDRESS <u>1014 N. CHARLES ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>MAE</u> Middle <u>N.</u> Last <u>BACHMANN</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 22 1877</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>10</u> Hours <u>4</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DETECTIVE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CRIME DETECTION</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>CARLISLE, PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PHILIP NORMAN</u>		14. MOTHER'S MAIDEN NAME <u>MATTIE (NOT KNOWN)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>C. RAY FREHN, CARLISLE, PA.</u>	
17. INFORMANT <u>C. RAY FREHN, CARLISLE, PA.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> DUE TO <u>of Colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> (c) <u>10 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>4 Months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item f8.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/4/67</u> to <u>MAY 16, 1967</u> , that (I) (we) lost saw the deceased alive on <u>5/2/67</u> , and that death occurred at <u>2 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Charles E. O'Donnell</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Charles E. O'Donnell, M.D.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>MAY 18, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MARYLAND</u>
24. FUNERAL DIRECTOR <u>WM COOK-BROOKS TOWSON</u>		25a. REC'D BY REGISTRAR <u>TOWSON, MD. 21204</u>	25b. REGISTRAR'S SIGNATURE <u>Wm Cook-Brooks</u>

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #13 & 14 Film #G388 5/9/67 pc

06203

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06193

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7302 School Lane		d. STREET ADDRESS 7302 School Lane	
3. NAME OF DECEASED (Type or print) Orval Roy Baker		4. DATE OF DEATH Month May Day 3 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1899
9. AGE (In years last birthday) yrs. 68		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rigger		10b. KIND OF BUSINESS OR INDUSTRY Steel	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Baker		14. MOTHER'S MAIDEN NAME Kimvall Baker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 236-01-8725	
17. INFORMANT Mrs. Edna N. Baker		Address 7302 School Lane	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Hypertensive C-V Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			INTERVAL BETWEEN ONSET AND DEATH —
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M.B. Davis, M.D.		22. DATE SIGNED MAY 5 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/6/67	
23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Ullrich Funeral Home Dundalk, Md.		25a. REC'D BY REGISTRAR MAY 5 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

08120

08120

1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the experimental procedures used to test the hypotheses. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The final part of the report is a conclusion and a list of references.

2. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the experimental procedures used to test the hypotheses. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The final part of the report is a conclusion and a list of references.

3. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the experimental procedures used to test the hypotheses. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The final part of the report is a conclusion and a list of references.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
06204						06194					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)					
a. COUNTY Baltimore						a. STATE Maryland					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 9807 Hilltop Drive						b. COUNTY Balto.					
c. LENGTH OF STAY IN 1b						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Parkville, Balto. Co.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9807 Hilltop Drive						d. STREET ADDRESS 9807 Hilltop Drive					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
MARGARET E. BARLOW						May 17th,			1967		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 1880		9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) Ireland				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas O'Neill						14. MOTHER'S MAIDEN NAME Julia Keelty					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No-				16. SOCIAL SECURITY NO. -		17. INFORMANT Mrs. J.E. Albert-9807 Hilltop Dr.				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Atherosclerosis with Cerebral Thrombosis 4500 DUE TO (b) Chronic Cardiac Decompensation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 10 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from May , 19 66 , to April , 19 67 , that (I) (we) last saw the deceased alive on 14 April 19 67 , and that death occurred at 1:45 M, from the causes and on the date stated above.											
22a. SIGNATURE Thomas J Brennan						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 19 May 1967		
22c. PHYSICIAN'S NAME (Type) Thomas Brennan M.D.						22d. ADDRESS 5217 Harford Road					
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE THEREOF 5/20/67		23c. NAME OF CEMETERY OR CREMATORY Cathedral Cem			23d. LOCATION (City, town or county) (State) Balto.			
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc.						ADDRESS 6500 York Rd. 21212			25a. REC'D BY REGISTRAR MAY 23 1967		
									25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

06206

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Baltimore County

CERTIFICATE OF DEATH

06195

1. PLACE OF DEATH a. COUNTY <u>Towson</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Mary Lida Bartlett</u>		4. DATE OF DEATH <u>May 11 - 19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-10-1877</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Orange Mills, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Dr. Jos. Turner Bartlett</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Frances M. Strickfus</u>		Address <u>615 Chestnut Cr</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO (b) <u>4200</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Broncho Pneumonia, Lobar Pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> , to <u>May 11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 9</u> , 19 <u>67</u> , and that death occurred at <u>10:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Normand Edward Day</u> M.D.		22b. DATE SIGNED <u>May 11, 1967</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>4-E-33rd St Baltimore Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/13/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>1217 St. Paul St.</u>		25a. REC'D BY REGISTRAR <u>Wm. Cook-Brooks Inc. Baltimore, Md. 21202</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE <u>MAY 16 1967</u>	

00130

STATE OF MICHIGAN

00302

IN SENATE, JANUARY 10, 1900.

REPORT OF THE

COMMISSIONER OF THE LAND OFFICE

FOR THE YEAR 1899.

ALBION, MICHIGAN:

W. B. BAKER, PRINTER.

1900.

THE STATE OF MICHIGAN,

DO HEREBY CERTIFY THAT

THE FOREGOING IS A TRUE

AND CORRECT COPY OF THE

REPORT OF THE

COMMISSIONER OF THE LAND OFFICE

FOR THE YEAR 1899.

IN WITNESS WHEREOF,

I HAVE HEREunto set my hand

and the seal of the State of Michigan,

this 10th day of January, 1900.

GOVERNOR.

ALBION, MICHIGAN.

REPORT OF THE
COMMISSIONER OF THE LAND OFFICE
FOR THE YEAR 1899.
ALBION, MICHIGAN:
W. B. BAKER, PRINTER.
1900.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06206

06196

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		
c. LENGTH OF STAY IN 1b 5 days			d. STREET ADDRESS 105 Chestnut St.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Armocost N. H.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Charles William Beall			4. DATE OF DEATH Month May Day 1 Year 1967		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1887		9. AGE (in years last birthday) 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railway Mail Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles E. Beall			14. MOTHER'S MAIDEN NAME Mary E. Clements		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-58-8836	17. INFORMANT Mrs. Mary E. O'Brien Address 4439 Old York Rd. Balto., Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2002 Lymphatic Sarcoma DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from April 10, 1967 to May 1, 1967 , that (I) (we) last saw the deceased alive on May 1, 1967 , and that death occurred at 1201 A M, from the causes and on the date stated above.					
22a. SIGNATURE Laurence C. Post			22b. DATE SIGNED 5/1/67		
22c. PHYSICIAN'S NAME (Type) Dr. Laurence C. Post			22d. ADDRESS 6805 York Rd., Balto., 12, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-3-67	23c. NAME OF CEMETERY OR CREMATORY St. Rose	23d. LOCATION (City, town or county) (State) Gaithersburg Md.		
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. ADDRESS 4905 York Rd. Balto., Md.			25e. REC'D BY REGISTRAR DATE MAY 2 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06207

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>608 Stacy Court</u>		d. STREET ADDRESS <u>3229 Shelburne Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Mary</u> Last <u>Beeler</u>		4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 6, 1893</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>not employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Melvin Holland</u>		14. MOTHER'S MAIDEN NAME <u>Delia Grady</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-03-4821</u>	
17. INFORMANT <u>Mr. Charles Beeler</u>		Address <u>608 Stacy Court</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>art sel cv disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u> <u>6 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> <u>none</u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>2/4, 1965</u> to <u>5/2, 1967</u> , that (I) (we) last saw the deceased alive on <u>5/2, 1968</u> , and that death occurred at <u>1 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Maurice Feldman</u> M.D.		22b. DATE SIGNED <u>5/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u> </u>		22d. ADDRESS <u>2 E READ ST</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 5, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Cockeysville, Maryland</u>	
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks</u> <u>Towson</u> ADDRESS <u>1050 York Road</u> <u>Towson, Maryland 21204</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>MAY 5 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06208

CERTIFICATE OF DEATH

06198

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RANDALLSTOWN		c. LENGTH OF STAY IN lb 6 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		d. STREET ADDRESS 4105 COLONIAL RD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BALTO. COUNTY GEN. HOSP		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ORVILLE Middle W. Last BENEDICT		4. DATE OF DEATH Month May Day 11 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/13/81
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Chief Inspector Balto. Commerce		10b. KIND OF BUSINESS INDUSTRY Chamber of Illinois	
11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? Country?	
13. FATHER'S NAME Jared D. BENEDICT		14. MOTHER'S MAIDEN NAME Rose Van Gundy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Carmelite B. Benedict same address		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO VASCULAR ACCIDENT 443X DUE TO H CVD; CHF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETIS MELLITUS		INTERVAL BETWEEN ONSET AND DEATH 11 DAYS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5/15/67 , 19 67 to 5/11/67 , 19 67 , that (I) (we) last saw the deceased alive on 5/11/67 , 19 67 , and that death occurred at 8:15 PM , from causes and on the date stated above.			
22a. SIGNATURE Dr. Gerald Maggidi		22b. DATE SIGNED 5/11/67	
22c. PHYSICIAN'S NAME (Type) GERALD MAGGIDI		22d. ADDRESS BALTO. COUNTY HOSP	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/15/1967	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial Cemet.	23d. LOCATION (City or Town) (County) (State) Towson, Md.
24. FUNERAL DIRECTOR Wm. F. Tschorn		25a. REC'D BY REGISTRAR DATE MAY 16 1967	25b. REGISTRAR'S SIGNATURE Charles J. ...

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00302

CERTIFICATE OF DEATH

Marshall

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div>1</div> <div>06203</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>Items#13&14 Film#G389 6/2/67 pc</div> <div>CERTIFICATE OF DEATH</div> <div>06199</div>									
1. PLACE OF DEATH a. COUNTY Baltimore					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS 1606 E. Lanvale Street				
Baptist Home of Maryland					Baptist Home of Md. 304				
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH
Annie			Lee		Bennett		May		Day 19, Year 1967
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
female	white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	April 8, 1864		103 yrs.	Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?	
housewife					Richmond, Va.			USA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Clement C. Tinsley					Margaret Glazebrook				
Albert P. Bennett					Clement C. Tinsley				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Address				
no					Baptist Home of Md. Owings Mills, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure 11221 DUE TO Arteriosclerotic C.V. Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 60 , to May 15, 1967 , that (I) (we) last saw the deceased alive on May 14, 1967 , and that death occurred at 5:00 M, from the causes and on the date stated above.									
22a. SIGNATURE			22b. DATE SIGNED			22c. PHYSICIAN'S NAME (Type)			
Dr. M. Paul Byerly			May 15, 1967			Dr. M. Paul Byerly			
22d. ADDRESS			22e. ADDRESS						
5820 York Rd.			5820 York Rd.						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		
Burial			5/23/67		Baltimore		Balto., Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Mitchell-Wiedefeld Home			6500 York Rd.			MAY 23 1967		Charles Judge	
			Balto., Md. 21212						

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Special

1. To be used for

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06210

06200

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b 45yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		e. STREET ADDRESS 2717 Westfield Ave.	
3. NAME OF DECEASED (Type or print) First Sarah Middle E. Last Bewick		4. DATE OF DEATH Month 5 Day 21 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/8/1899
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Operator		10b. KIND OF BUSINESS OR INDUSTRY G.E. Co.	
11. BIRTHPLACE (County & State, or foreign country) England		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Jennings		14. MOTHER'S MAIDEN NAME Catherine Gorman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 217-12-9881A	
17. INFORMANT Mrs. Dorothea Horsey		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) terminal stage of multiple myeloma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Hypostatic pneumonia			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/25/1967 , to 5/21/1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 5/21/1967 , and that death occurred at 8:25pm , from causes and on the date stated above.			
22a. SIGNATURE Reynaldo Orjuela-Gomez, M.D.		22b. DATE SIGNED May 22, 1967	
22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/25/67.	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR MAY 24 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

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Richard Johnson

Richard Johnson

212-11-0111

Richard Johnson

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
06211					06201				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY Baltimore MARYLAND					a. STATE Maryland b. COUNTY _____				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21206				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital					d. STREET ADDRESS 5853 Belair Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First John Middle Henry Last Bilzer					Month May Day 21 Year 19 67				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 9-22-01	9. AGE (In years last birthday) yrs. 65	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY Martin Co.		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Edward Bilzer					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-01-9329A		17. INFORMANT Mrs. Mary Bilzer			Address (Same)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction. H201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Occlusion, left coronary artery. (c) Arteriosclerosis, generalized.									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus.									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that XX (this hospital) attended the deceased from April 8, 19 67 to May 21, 19 67 , that XX (we) last saw the deceased alive on May 21, 19 67 , and that death occurred at 4:55A M, from causes and on the date stated above.									
22a. SIGNATURE Manuel S. Cockburn					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED May 21, 1967	
22c. PHYSICIAN'S NAME (Type) Manuel S. Cockburn, M.D.					22d. ADDRESS 7620 York Road, Towson, Md. 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/24/67.		23c. NAME OF CEMETERY OR CREMATORY Holy redeemer Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214					25a. REC'D BY REGISTRAR DATE MAY 22 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

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**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06212

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06202

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McDonald,		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center				d. STREET ADDRESS Rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle A. Last BISH				4. DATE OF DEATH Month May Day 4, Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/28/16		9. AGE (In years last birthday) 51 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY GENERAL CON. CO.		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CLARENCE BISH				14. MOTHER'S MAIDEN NAME ETHEL WITSON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address MARY BISH, MCDONALD, PA.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dissecting aneurysm of aorta 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate		M.D. Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED May 5, 1967	
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/8/67		23c. NAME OF CEMETERY OR CREMATORY MIDIVAY CEM.		23d. LOCATION (City or Town) (County) (State) MIDIVAY, PA.	
24. FUNERAL DIRECTOR HOWARD H. HUBBARD				ADDRESS 4107 WILKENS AVE. 21229		25a. REC'D BY REGISTRAR MAY 8 1967	
						25b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

Reg. Dist. No.

06203

06213

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOUSE IN PINES CONV. HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Maggie STREAGLE</u> First Middle Last				4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1967</u>			
5. SEX <u>7</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/8/88</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>GLOUCESTER, VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>EUGENE STREAGLE</u>				14. MOTHER'S MAIDEN NAME <u>MAUDE DUNSTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217200160</u>		17. INFORMANT Address <u>HARRY EMERSON</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>generalized abdominal carcinoma</u> 1531 DUE TO <u>Carcinoma of Transverse Colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Unknown.</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>5 Mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 9, 1967</u> to <u>May 21, 1967</u> , that I last saw the deceased alive on <u>May 9, 1967</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bradley Laugharty</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>5-21-67</u>			
PHYSICIAN'S NAME (Type) <u>M.D. 12647 Francis Ave Baltimore Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/24/67</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BELLAMY CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>GLOUCESTER, VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>BRIDGES FUNL. HOME GLOUCESTER, VA.</u>				24a. REG'D BY REGISTRAR DATE <u>MAY 22 1967</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
<u>E. S. Mac Math Catonsville Md</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06214									
06204									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>(Govans) Baltimore 12</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore (Govans)</u> 03.1				
c. LENGTH OF STAY IN 1b <u>26 yrs</u>					d. STREET ADDRESS <u>322 Regester Avenue</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>322 Regester Avenue</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>MONA</u> Last <u>BOLLINGER</u>					4. DATE OF DEATH Month <u>May</u> Day <u>17</u> , Year <u>1967</u>				
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 20, 1908</u>		9. AGE (In years last birthday) <u>58</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles L. Brauning</u>					14. MOTHER'S MAIDEN NAME <u>Mollie Shipley</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT <u>J. Wilbur Bollinger</u>		
							Address <u>322 Regester Ave Baltimore 12, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>May 15, 1967</u> to <u>May 17, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 16, 1967</u> , and that death occurred at <u>10:45 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Theodore G. de Cuerdo</u>					22b. DATE SIGNED <u>May 17, 1967</u>				
22c. PHYSICIAN'S NAME (Type) <u>Theodore G. de Cuerdo</u>					22d. ADDRESS <u>423 Thornhill Rd. Lutherville-Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>					23b. DATE THEREOF <u>5/20/67</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>Providence Cemetery</u>					23d. LOCATION (City, town or county) (State) <u>Finksburg RD, Maryland</u>				
24. FUNERAL DIRECTOR <u>J. E. Myers, Jr., Westminster, Md.</u>					25a. REC'D BY REGISTRAR <u>MAY 22 1967</u>				
					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

MEDICAL CERTIFICATION

00320

00310

RECEIVED
JAN 15 1967
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535
MEMORANDUM
TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
[The remainder of the memorandum text is illegible due to extreme fading.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06215

CERTIFICATE OF DEATH

Items #8, 9, 16, 23a, b, c, d, e, f, g, h, i, j, k, l, m, n, o, p, q, r, s, t, u, v, w, x, y, z, aa, ab, ac, ad, ae, af, ag, ah, ai, aj, ak, al, am, an, ao, ap, aq, ar, as, at, au, av, aw, ax, ay, az, ba, bb, bc, bd, be, bf, bg, bh, bi, bj, bk, bl, bm, bn, bo, bp, bq, br, bs, bt, bu, bv, bw, bx, by, bz, ca, cb, cc, cd, ce, cf, cg, ch, ci, cj, ck, cl, cm, cn, co, cp, cq, cr, cs, ct, cu, cv, cw, cx, cy, cz, da, db, dc, dd, de, df, dg, dh, di, dj, dk, dl, dm, dn, do, dp, dq, dr, ds, dt, du, dv, dw, dx, dy, dz, ea, eb, ec, ed, ee, ef, eg, eh, ei, ej, ek, el, em, en, eo, ep, eq, er, es, et, eu, ev, ew, ex, ey, ez, fa, fb, fc, fd, fe, ff, fg, fh, fi, fj, fk, fl, fm, fn, fo, fp, fq, fr, fs, ft, fu, fv, fw, fx, fy, fz, ga, gb, gc, gd, ge, gf, gg, gh, gi, gj, gk, gl, gm, gn, go, gp, gq, gr, gs, gt, gu, gv, gw, gx, gy, gz, ha, hb, hc, hd, he, hf, hg, hh, hi, hj, hk, hl, hm, hn, ho, hp, hq, hr, hs, ht, hu, hv, hw, hx, hy, hz, ia, ib, ic, id, ie, if, ig, ih, ii, ij, ik, il, im, in, io, ip, iq, ir, is, it, iu, iv, iw, ix, iy, iz, ja, jb, jc, jd, je, jf, jg, jh, ji, jj, jk, jl, jm, jn, jo, jp, jq, jr, js, jt, ju, jv, jw, jx, jy, jz, ka, kb, kc, kd, ke, kf, kg, kh, ki, kj, kk, kl, km, kn, ko, kp, kq, kr, ks, kt, ku, kv, kw, kx, ky, kz, la, lb, lc, ld, le, lf, lg, lh, li, lj, lk, ll, lm, ln, lo, lp, lq, lr, ls, lt, lu, lv, lw, lx, ly, lz, ma, mb, mc, md, me, mf, mg, mh, mi, mj, mk, ml, mm, mn, mo, mp, mq, mr, ms, mt, mu, mv, mw, mx, my, mz, na, nb, nc, nd, ne, nf, ng, nh, ni, nj, nk, nl, nm, nn, no, np, nq, nr, ns, nt, nu, nv, nw, nx, ny, nz, oa, ob, oc, od, oe, of, og, oh, oi, oj, ok, ol, om, on, oo, op, oq, or, os, ot, ou, ov, ow, ox, oy, oz, pa, pb, pc, pd, pe, pf, pg, ph, pi, pj, pk, pl, pm, pn, po, pp, pq, pr, ps, pt, pu, pv, pw, px, py, pz, qa, qb, qc, qd, qe, qf, qg, qh, qi, qj, qk, ql, qm, qn, qo, qp, qq, qr, qs, qt, qu, qv, qw, qx, qy, qz, ra, rb, rc, rd, re, rf, rg, rh, ri, rj, rk, rl, rm, rn, ro, rp, rq, rr, rs, rt, ru, rv, rw, rx, ry, rz, sa, sb, sc, sd, se, sf, sg, sh, si, sj, sk, sl, sm, sn, so, sp, sq, sr, ss, st, su, sv, sw, sx, sy, sz, ta, tb, tc, td, te, tf, tg, th, ti, tj, tk, tl, tm, tn, to, tp, tq, tr, ts, tt, tu, tv, tw, tx, ty, tz, ua, ub, uc, ud, ue, uf, ug, uh, ui, uj, uk, ul, um, un, uo, up, uq, ur, us, ut, uu, uv, uw, ux, uy, uz, va, vb, vc, vd, ve, vf, vg, vh, vi, vj, vk, vl, vm, vn, vo, vp, vq, vr, vs, vt, vu, vv, vw, vx, vy, vz, wa, wb, wc, wd, we, wf, wg, wh, wi, wj, wk, wl, wm, wn, wo, wp, wq, wr, ws, wt, wu, wv, ww, wx, wy, wz, xa, xb, xc, xd, xe, xf, xg, xh, xi, xj, xk, xl, xm, xn, xo, xp, xq, xr, xs, xt, xu, xv, xw, xx, xy, xz, ya, yb, yc, yd, ye, yf, yg, yh, yi, yj, yk, yl, ym, yn, yo, yp, yq, yr, ys, yt, yu, yv, yw, yx, yy, yz, za, zb, zc, zd, ze, zf, zg, zh, zi, zj, zk, zl, zm, zn, zo, zp, zq, zr, zs, zt, zu, zv, zw, zx, zy, zz

06205

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 2yr7mth18dys d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1500 West Baltimore Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle G. Last Bookhultz		4. DATE OF DEATH Month MAY Day 24 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1894 9. AGE (In years last birthday) 72 1/3 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME	
14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. 215-03-2622		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (A) (this hospital) attended the deceased from Oct. 6, 1964 , to 5-24, 1967 , that (I) (we) last saw the deceased alive on 5-24, 1967 , and that death occurred at 6:19 P.M. , from causes and on the date stated above.			
22a. SIGNATURE Morris Meiller		22b. DATE SIGNED 5/24/67	
22c. PHYSICIAN'S NAME (Type) MORRIS MEILLER, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF May 29, 1967	23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Farley - Cavanaugh		25a. REC'D BY REGISTRAR 6601 Frodenick DATE MAY 29 1967	
25b. REGISTRAR'S SIGNATURE Charles Jones			

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UNITED STATES OF AMERICA

IN SENATE
January 1, 1900

REPORT
OF THE
COMMISSIONER OF THE
GENERAL LAND OFFICE

IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
JANUARY 1, 1899

AND
A REPORT
ON THE
LANDS BELONGING TO THE
UNITED STATES

BY
JAMES H. BECK,
COMMISSIONER OF THE
GENERAL LAND OFFICE

WASHINGTON:
GOVERNMENT PRINTING OFFICE:
1900

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06216

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06206

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN Tb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PINE RIDGE GOLF COURSE		d. STREET ADDRESS 4312 BARRINGTON RD.	
3. NAME OF DECEASED (Type or print) LOUIS Charles BORCHERDING, Jr.		4. DATE OF DEATH Month MAY Day 30 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/7/03
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Proctor & Gamble	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis C. Borcharding, Sr.		14. MOTHER'S MAIDEN NAME Bertha Kuhlow	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 214-01-8979	
17. INFORMANT Mrs. Helen R. Borcharding Barrington Rd.		Address 4312	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4201 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William A. Pillsbury M.D.		22. DATE SIGNED 5/30/67	
EXAMINER'S NAME (Type) William A. Pillsbury		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) _____ MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/2/67	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Howard H. Hubbard 4107 Wilkens Ave. 21229		25a. REC'D BY REGISTRAR JUN 2 1967	
		25b. REGISTRAR'S SIGNATURE [Signature]	

00330

00330

00330

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06217

CERTIFICATE OF DEATH

06208

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1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODLAWN 21207</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUMMIT HOME</u>		d. STREET ADDRESS <u>5920 JOHNNYCAKE RD</u>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>BERNARD</u> Last <u>BREITENBACH</u>		4. DATE OF DEATH Month <u>5</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/4/91</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B.Y.O. R.R.</u>	9. AGE (In years last birthday) <u>76</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>RUDOLPH BREITENBACH</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE HENNEGIN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>FRANKLIN R. BREITENBACH</u>	
17. INFORMANT <u>FRANKLIN R. BREITENBACH</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA PLEURA, LEFT</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 MOS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/6</u> , 19 <u>66</u> to <u>5/9</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>5/8</u> , 19 <u>67</u> , and that death occurred at <u>9:20</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Thos E Roach</u>		22b. DATE SIGNED <u>5/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOS E ROACH</u>		22d. ADDRESS <u>5550 BALTO VATE LINE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5/12/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LOUNDON PARK</u>	23d. LOCATION (City or town) (County) (State) <u>BALTO MD</u>
24. FUNERAL DIRECTOR <u>E.S. MALNABB</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAY 15 1967</u>	

00320

183

10-11-1977 10:00 AM

06218

CERTIFICATE OF DEATH

Reg. Dist. No.

06209

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural-Rosedale</i>		c. LENGTH OF STAY IN lb <i>10 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1328 Evering Avenue</i>		e. STREET ADDRESS <i>1328 Evering Avenue</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Christine G. Brewer</i>		4. DATE OF DEATH Month Day Year <i>May 20 1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 1, 1907</i>
9. AGE (In years last birthday) yrs. <i>59</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph Levy</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>218 09 1275</i>	
17. INFORMANT <i>Chrystelle Brockmeyer</i>		Address <i>2220 Jaycee Dr. Joppa, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial failure</i> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Cardio-Vascular disease</i> DUE TO (c) <i>Diabetes Mellitus</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>10 yrs</i> <i>15 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 1</i> , 19 <i>67</i> , to <i>May 20</i> , 19 <i>67</i> , that I last saw the deceased alive on <i>May 20</i> , 19 <i>67</i> , and that death occurred at <i>1 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Baltimore 21206</i> DATE SIGNED <i>5/20/67</i> ACTUAL SIGNATURE <i>G. M. Baumgardner</i> M.D. PHYSICIAN'S NAME (Type) <i>G. M. BAUMGARDNER</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 22, 1967</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Phyllis G. Gosh</i>		ADDRESS <i>1211 Chesaco Avenue</i>	
24a. REC'D BY REGISTRAR DATE <i>MAY 22 1967</i>		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

03209

03209

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-2. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06213

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06210

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex c. LENGTH OF STAY IN It Essex d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Essex House Tavern				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex d. STREET ADDRESS 446 Eastern Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HERBERT RICHARD BRODNICK			4. DATE OF DEATH Month 5 Day 3 Year 19 67				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 36 yrs.		9. AGE (In years last birthday) 36 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR		10b. KIND OF BUSINESS OR INDUSTRY EASTERN TAXI CAB CO.		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND			
13. FATHER'S NAME BENJAMIN BRODNICK			14. MOTHER'S MAIDEN NAME ELIZABETH FISHER				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT MR. LOUIS BRODNICK, 3921 BANCROFT ROAD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor pulmonale 287X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Obesity - (Pickwickian Syndrome) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE RUSSELL S. FISHER, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 5-3-67			
EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/4/67		23c. NAME OF CEMETERY OR CREMATORY OHEB SHALOM			
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REIST., RD.		25a. REC'D BY REGISTRAR MAY 8 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge			
23d. LOCATION (City or Town) BALTIMORE, MARYLAND		23e. (County) (State)					

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Health Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06220

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06211

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere				c. LENGTH OF STAY IN b 21 Years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2523 S. Snyder Ave.				d. STREET ADDRESS 2523 S. Snyder Ave.			
3. NAME OF DECEASED (Type or print) First Venton Middle J. Last Brooks				4. DATE OF DEATH Month May Day 16 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/1/15		9. AGE (In years last birthday) 52 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Scale Dept.				10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME David Brooks				14. MOTHER'S MAIDEN NAME Clevie Brooks			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-07-7081		17. INFORMANT (Wife) Address Mrs. Florence Brooks, 2523 S. Snyder Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO (b) Hypertensive Cardiovascular DUE TO (c) Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Alcoholism By History							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Theodore C. Patterson M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> 105 Main St. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Dundalk, DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Maryland 5/16/67 Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/19/67		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.				25a. REC'D BY REGISTRAR DATE MAY 18 1967		25b. REGISTRAR'S SIGNATURE <i>Arlanda Duda</i>	

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06384

Washington

Washington

Washington

Boys' Club

Boys' Club

Boys' Club

2525 S. Street Ave.

2525 S. Street Ave.

Brooklyn

Brooklyn

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U. S. A.

Washington, D. C.

Washington, D. C.

Boys' Club

Boys' Club

Boys' Club

(U. S. A.)

25-07-1981

Mr. Thomas C. Peterson

to

105 Main St.

Brooklyn

Boys' Club

Thomas C. Peterson

Boys' Club

Boys' Club

Boys' Club

Boys' Club

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06221

CERTIFICATE OF DEATH

06212

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY in 1b 64 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 1408 N. MOUNT STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANK Middle VERNON Last BROWN				4. DATE OF DEATH Month MAY Day 5 Year 19 67			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 6, 1907		9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RIGGER		10b. KIND OF BUSINESS OR INDUSTRY SHIP YARD		11. BIRTHPLACE (County & State, or foreign country) BALITTLETON, N. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK BROWN				14. MOTHER'S MAIDEN NAME MARTHA HAWKINS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 213 09 12 91		17. INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL EDEMA 5811 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) LAENNEC'S CIRRHOSIS DUE TO (c) CHRONIC ALCOHOLISM							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) HEART DISEASE (HYPERTROPHY) UNKNOWN ETIOLOGY							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from 3/2/67 , 19____, to 5/5/67 , 19____, that (1) (we) last saw the deceased alive on 5/5/67 , 19____, and that death occurred at 6:30AM , from causes and on the date stated above.							
22a. SIGNATURE <i>Neilon Neilson</i> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/5/67	
22c. PHYSICIAN'S NAME (Type) NEILON NEILSON, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-9-67	23c. NAME OF CEMETERY OR CREMATORY Baltimore NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR <i>Vernon B. Bailey</i>				ADDRESS KELSON FUNERAL HOME		25a. REC'D BY REGISTRAR DATE MAY 9 1967	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
2DM 1/65

06222

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06213

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN 1b 16 Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 133 Pleasant Hill Road		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills d. STREET ADDRESS 133 Pleasant Hill Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Millie Middle Catherine Last Brown		4. DATE OF DEATH Month MAY Day 14 Year 1967				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/6/1880	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months 03 Days 1	IF UNDER 24 HRS. Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Housework-Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home.		11. BIRTHPLACE (County & State, or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME David H. Bair			14. MOTHER'S MAIDEN NAME Anna Mary Myers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 196-16-9926		17. INFORMANT 133 Pleasant Hill Road., Mrs. Claude H. Miller Owings Mills, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC C.V. DISEASE WITH DEED (c) CARDIAC DECOMPENSATION INTERVAL BETWEEN ONSET AND DEATH 24 HRS YEARS					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JUNE, 1951 , to MAY 14, 1967 , that (I) was last saw the deceased alive on MAY 13 1967 , and that death occurred at 2:50 PM , from the causes and on the date stated above.						
22a. SIGNATURE Martin E. Strobel		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 14, 1967		
22c. PHYSICIAN'S NAME (Type) MARTIN E. STROBEL		22d. ADDRESS 48 MAIN ST. REISTERSTOWN MD				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/17/67		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		23d. LOCATION (City, town or county) (State) Silver Run, Carroll Co. Md.
24. FUNERAL DIRECTOR Richard A. Little		ADDRESS Littlestown, Pa.		25a. REC'D BY REGISTRAR MAY 16 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06223

06214

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c. LENGTH OF STAY IN 1b 2 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 2027 Sinclair Lane	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIE (William) BROWN		4. DATE OF DEATH Month 5 Day 10 Year 1967	
5. SEX M	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12.12.1917
9. AGE (In years lost birthday) 49 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME LEMMETT BROWN	
14. MOTHER'S MAIDEN NAME EMMA BUTLER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. 264-05-6125		17. INFORMANT Records, Mount Wilson State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac tamponade DUE TO (b) Pericardial effusion DUE TO (c) Pulmonary inflammatory infiltrate		INTERVAL BETWEEN ONSET AND DEATH 2 days 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5:8 , 19 67 , to 5:10 , 19 67 , that (I) (we) last saw the deceased alive on 5:10 19 67 , and that death occurred at 5:10 AM , from causes and on the date stated above.			
22a. SIGNATURE W. Newcomer		22b. DATE SIGNED 5.10.1967	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF May 15/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.	23d. LOCATION (City or Town) (County) (State) Calvary, Md.
24. FUNERAL DIRECTOR Wm. E. Elicker 1129 N. Charles St.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAY 12 1967	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06224

06215

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTO. MEDICAL CENTER.			d. STREET ADDRESS 214 HOPKINS ROAD		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) CHARLES MULLEN BURGEES			4. DATE OF DEATH Month MAY Day 16 Year 1967		
5. SEX MALE	6. COLOR OR RACE CAUC.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-4-95		9. AGE (In years last birthday) 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - ELECTRICIAN		10b. KIND OF BUSINESS OR INDUSTRY Western Electric Co.		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME XXXXXXXXXX			
14. MOTHER'S MAIDEN NAME XXXXXXXXXX		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) UNKNOWN			
16. SOCIAL SECURITY NO. 216-01-9248		17. INFORMANT PT'S CHART Address Mrs. Evelyn P. Burgee			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory failure 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Post-operative irreversible shock DUE TO (c) Ruptured abdominal aortic aneurysm.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HDV INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from May 16, 1967 , to May 16, 1967 , that (I) (we) last saw the deceased alive on May 16, 1967 , and that death occurred at 9:25 PM , from causes and on the date stated above.					
22a. SIGNATURE Robert W. Smith M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5-16-67	
22c. PHYSICIAN'S NAME (Type) Dr. Robert W. Smith		22d. ADDRESS Greater Balto. Med. Center			
23a. BURIAL, CREMATION, BURNING, etc. (Specify) BURIAL		23b. DATE THEREOF 5/20/67		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge	
23d. LOCATION (City or Town) (County) (State) Baltimore, Md.					
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home		ADDRESS 6500 York Rd.		25a. REC'D BY REGISTRAR MAY 23 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge					

Balto., Md. 21212

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MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06225

CERTIFICATE OF DEATH

06216

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chesapeake Manor Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 306 E. 32nd Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ella Middle Cobb Last Bush		4. DATE OF DEATH Month May Day 24 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/18/83
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Johns Hopkins Hosp. Maryland	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert H. Bush		MOTHER'S MAIDEN NAME Margaret Elizabeth Hughes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-30-2972	
17. INFORMANT Frederick J. Singley, Jr.		Address First Nat'l Bank Bldg.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from June 1958 , to 5-24, 1967 , that (1) (we) last saw the deceased alive on 5-23, 1967 , and that death occurred at 7 A M, from causes and on the date stated above.			
22a. SIGNATURE Franklin E. Leslie		22b. DATE SIGNED 5-25-67	
22c. PHYSICIAN'S NAME (Type) Dr. Franklin Leslie		22d. ADDRESS 302 E. 33rd St.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/26/67	23c. NAME OF CEMETERY OR CREMATORY Greenmount	23d. LOCATION (City or Town) (County) (State) Baltimore Md.
24. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co		25a. REC'D BY REGISTRAR 12 DATE MAY 26 1967	
ADDRESS 4905 York Rd.		25b. REGISTRAR'S SIGNATURE Charles Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06226

CERTIFICATE OF DEATH

06217

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PERRY HALL</u>		c. LENGTH OF STAY IN Tb <u>34 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9714 BELAIR ROAD</u>		d. STREET ADDRESS <u>9714 BELAIR ROAD</u>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>Anthony</u> Last <u>BUTT</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 9, 1897</u>
9. AGE (In years, last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MOTEL</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY S. BUTT</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH KRISKEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> <u>NONE</u> <u>?</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>WILBERT GRIES</u>		Address <u>1735 W. PRATT ST.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of right lung</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> 163X			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 6, 1967</u> , to <u>May 7, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 7, 1967</u> , and that death occurred at <u> </u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Frank N. Goode</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>FRANK N. GOODE, MD.</u>		22d. ADDRESS <u>2701 N. CALVERT ST.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-11-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MD.</u>	
24. FUNERAL DIRECTOR <u>Francis W. Miller 2101 Tudman Ave.</u>		25a. REC'D BY REGISTRAR <u>MAY 9 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

02513

SS20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06227

CERTIFICATE OF DEATH

06218

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Baltimore</u> b. COUNTY <u>md.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb <u>1 day.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3312 W. Strathmore Ave. Balt. 21215</u>		d. STREET ADDRESS <u>Baltimore County General.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>Louise C. Byers.</u>		4. DATE OF DEATH Month <u>5</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-14-1909</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>yes.</u>	
13. FATHER'S NAME <u>Charles Zentz</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Bankard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Loring Byers-8728 Liberty Rd. Randallstown</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>ASHD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASHD</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Abdomen</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-7</u> , 19 <u>67</u> , to <u>5-8</u> , 19 <u>67</u> that (I) (we) lost saw the deceased alive on <u>5-8</u> , 19 <u>67</u> , and that death occurred at <u>5-8</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Ruperto Manankil</u>		22b. DATE SIGNED <u>5-8-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RUPERTO MANANKIL</u>		22d. ADDRESS <u>BOB H</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/15/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Office- 505 Cathedral St. Balt. 21201</u>	
24. FUNERAL DIRECTOR <u>Loring Byers-8728 Liberty Rd. Randallstown, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 15 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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3015 W. Baltimore Ave. Baltimore, MD 21201

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06228

CERTIFICATE OF DEATH

06219

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>514 E. 39th St</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>				d. STREET ADDRESS <u>514 E. 39th St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Unice Catherine Byrd</u> First Middle Last				4. DATE OF DEATH <u>5</u> <u>8</u> <u>1967</u> Month Day Year			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Can</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/9/84</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NA homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NA</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Balto., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George C. Parks</u>				14. MOTHER'S MAIDEN NAME <u>Marjorie Ella</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NA</u> (If yes give war or dates of service) <u>NA</u>		16. SOCIAL SECURITY NO. <u>218-542467</u>		17. INFORMANT <u>Mrs. Alameda Rithmiller</u> <u>Patient Chart</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive Heart Failure &</u> DUE TO (c) <u>Cardiac Arrhythmia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>46 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I(a))							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work ot work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 2</u> , 19 <u>67</u> , to <u>May 8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 8</u> , 19 <u>67</u> , and that death occurred at <u>11:15 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Ludmila M. Oteyza</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>5/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. L. [redacted] M. OTEYZA</u>				22d. ADDRESS <u>GBMC, Charles St. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 11, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Balto., Md.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Mitchell-Wiedefeld Home 6500 York Rd. Balto., Md. 21212</u>				25a. REC'D BY REGISTRAR <u>MAY 9 1967</u> DATE		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06223

CERTIFICATE OF DEATH

06220

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>908 C ASHBRIDGE DR</u>		d. STREET ADDRESS <u>908 C ASHBRIDGE DR</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>THELMA BYRNE</u>		4. DATE OF DEATH Month Day Year <u>MAY 8 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 8 1909</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LEO A. BLANKENSHIP</u>		14. MOTHER'S MAIDEN NAME <u>JOSEPHINE LOTH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>PAUL BYRNE</u>		Address <u>ABOVE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1 pulmonary infection</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-1</u> , 1967, to <u>5-8</u> , 1967 that (I) (we) last saw the deceased alive on <u>5-8</u> 1967, and that death occurred at <u>3A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>MAY 11, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HOLLY HILLS</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO. MD</u>
24. FUNERAL DIRECTOR <u>JG CONNELLY SONS</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 12 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

2530

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06230

CERTIFICATE OF DEATH

06221

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2221 Baltimore 21216</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		d. STREET ADDRESS <u>2221 ELSINORE AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>A.</u> Middle <u>Brown</u> Last <u>Caldwell</u>		4. DATE OF DEATH Month <u>5</u> Day <u>14</u> Year <u>67</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Can.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-2-90</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MINISTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Williamsport, PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>John E. Caldwell</u>		14. MOTHER'S MAIDEN NAME <u>ANNA BROWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNK</u>		16. SOCIAL SECURITY NO. <u>212-14-3168</u>	
17. INFORMANT <u>MARGARET WYSONG -</u>		Address <u>Chart - 1902 Princeton Place Rockville Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Resp. Failure</u> 1810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sarcoma of bladder</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that <u> </u> (this hospital) attended the deceased from <u>May 14, 1967</u> , to <u>May 14, 1967</u> , that <u> </u> (we) last saw the deceased alive on <u>12:05 AM 19</u> , and that death occurred at <u>12:05 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Dennis Chan</u>		22b. DATE SIGNED <u>May 14 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>DENIS CHAN</u>		22d. ADDRESS <u>G B M C</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5-18-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md</u>
24. FUNERAL DIRECTOR <u>ELLSWORTH ARMACOST - 4401 Liberty Heights Ave</u>		25a. RECEIVED BY REGISTRAR <u> </u> DATE <u>May 17 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

06231

06222

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7416 Monita Road		d. STREET ADDRESS 7416 Monita Road	
3. NAME OF DECEASED (Type or print) First Bertha Middle M. Last Carey		4. DATE OF DEATH Month May Day 7 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 7, 1889
9. AGE (In years birth day) yrs. 78		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (County & State, or foreign country) Balto. Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harrold W. Wille, Alexander		14. MOTHER'S MAIDEN NAME (unknown) Strauss	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 217-36-3761 T	
17. INFORMANT Mr. Jerry P. Carey		Address Pikesville Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Kidney, left 180X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) Dr. Lee J. Gaver attended the deceased from May , 19 1952 to May , 19 67 , that (I) last saw the deceased alive on May 1 , 19 67 , and that death occurred at 4:45 PM , from causes and on the date stated above.			
22a. SIGNATURE Dr. Lee J. Gaver		22b. DATE SIGNED 5/8/67	
22c. PHYSICIAN'S NAME (Type) Dr. Lee J. Gaver		22d. ADDRESS 1 Mallow Hill Rd. Balto 29, Md	
23a. BURIAL, CREMATION, REINTERMENT (Y) Buried		23b. DATE THEREOF 5/10/67	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City or Town) (County) (State) 3801 Frederick Rd Balto Md.	
24. FUNERAL DIRECTOR Loring Byers		ADDRESS 8728 Liberty Rd	
25a. REC'D BY REGISTRAR MAY 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06232

CERTIFICATE OF DEATH

06223

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN 1b 16 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 11 BRISTOL AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First STANLEY Middle NMI Last CARSON				4. DATE OF DEATH Month MAY Day 6 Year 1967			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4/18/09	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER		10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		11. BIRTHPLACE (County & State, or foreign country) CANADA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALBERT CARSON				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES KOREAN		16. SOCIAL SECURITY NO. 212 12 22 92		17. INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE 570.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) LIVER FAILURE DUE TO (c) PARALYTIC ILEUS						INTERVAL BETWEEN ONSET AND DEATH 48 Hours 1 Week 1 Week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 20 , 19 67 , to May 6 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 6 , 19 67 , and that death occurred at 8 P.M. , from causes on and on the date stated above.							
22a. SIGNATURE <i>Milton Ginsberg</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/8/67	
22c. PHYSICIAN'S NAME (Type) MILTON GINSBERG, M.D.				22d. ADDRESS VA Hospital, Fort Howard, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF MAY 10, 1967	23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland			
24. FUNERAL DIRECTOR George J. Gonce Funeral Home				25a. REC'D BY REGISTRAR 4001 Gov. Ritchie Highway Balto Md		25b. REGISTRAR'S SIGNATURE <i>John J. Judge</i>	
VR A15 (4) 25M 1/67				DATE MAY 11 1967			

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CARDIO-PULMONARY CENTER

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DEPARTMENT OF

RESEARCH

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ALBERT GARDEN

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George A. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06233

CERTIFICATE OF DEATH

06224

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN 1b 14 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 3200 OLD NORTH POINT ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ANTHONY STEVEN CATRAMADOS				4. DATE OF DEATH Month Day Year MAY 1 19 67			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/3/29		9. AGE (In years last birthday) 38 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER		10b. KIND OF BUSINESS OR INDUSTRY BARBER SHOP		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME STRATIS CATRAMADOS				14. MOTHER'S MAIDEN NAME EUGENIE CALAVETINOS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 217 22 91 89		17. INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4201 DUE TO ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 3836 (b) ARTERIOSCLEROTIC HEART DISEASE (c) BRONCHOGENIC CYST						INTERVAL BETWEEN ONSET AND DEATH MINUTES UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 4/17/67 , 19__ to 5/1/67 , 19__, that (if) we last saw the deceased alive on 5/1/67 , 19__, and that death occurred at 2:45P M, from causes and on the date stated above.							
22a. SIGNATURE <i>Peter J. Juvan</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/2/67	
22c. PHYSICIAN'S NAME (Type) PETER J. JUVAN, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL		5/4/67		BALTIMORE NAT. CEMETERY		BALTIMORE, MD.	
24. FUNERAL DIRECTOR Doris S. Krause		ADDRESS KRAUSE FUNERAL HOME		RECORDED BY REGISTRAR MAY 4 1967		REGISTRAR'S SIGNATURE <i>John S. Juvan</i>	
		1216 S. CHARLES ST.		BALTIMORE, MD.			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
06234 CERTIFICATE OF DEATH 06225

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN ID 22yr4mth21lds d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1101 S. Mason Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret Christner		4. DATE OF DEATH May 9 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1883
9. AGE (in years last birthday) 83 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 219-54-3068J1	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Duodenal ulcer with bleeding			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that AS (this hospital) attended the deceased from Dec. 18 19 64 to May 9 19 67 , that no (we) last saw the deceased alive on May 9 19 67 , and that death occurred at 12:05 M, from the causes and on the date stated above.			
22a. SIGNATURE Anthony J. Young, M.D.		22b. DATE SIGNED 5-9-67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF May 11 1967	
23c. NAME OF CEMETERY OR CREMATORY New Catholic		23d. LOCATION (City, town or county) (State) Old Frederick Road Baltimore	
24. FUNERAL DIRECTOR Krause Funeral Home 1216 S Charles St		25a. REC'D BY REGISTRAR MAY 15 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06235

CERTIFICATE OF DEATH

06226

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 3mth20dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 216 East Cross Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gordon Middle Oscar Last Cole				4. DATE OF DEATH Month May Day 14 Year 1967			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 28, 1902		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) truck driver		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Oscar Cole				14. MOTHER'S MAIDEN NAME Jenny Scott			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Army 1918-19		16. SOCIAL SECURITY NO. 214-01-8514		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lungs 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan. 24 , 19 62 , to May 14 19 67 , that (*) (we) last saw the deceased alive on May 14 19 67 , and that death occurred at 7:45 p.m., from causes and on the date stated above.							
22a. SIGNATURE Stella Wachslor		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-15-67			
22c. PHYSICIAN'S NAME (Type) Stella Wachslor, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/18/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc., 1501 East Fort Avenue		25a. REC'D BY REGISTRAR MAY 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06236

CERTIFICATE OF DEATH

06227

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>601 Sussex Road</u>				d. STREET ADDRESS <u>601 Sussex Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Isabelle</u> Middle <u>V.</u> Last <u>Conway</u>				4. DATE OF DEATH Month <u>May</u> Day <u>28</u> Year <u>1967</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-14-1884</u>		9. AGE (In years last birthday) <u>82</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thompson</u>				14. MOTHER'S MAIDEN NAME <u>not known</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>214323111A</u>		17. INFORMANT <u>Thomas O. Carroll</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) <u>20 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>May 17, 1967</u> to <u>May 29, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 17, 1967</u> , and that death occurred at <u>5:30 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Thomas J. Brennan</u>				22b. DATE SIGNED <u>29 May 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Thomas J. Brennan, M.D.</u>	
22d. ADDRESS <u>5217 Harford Road Baltimore 21214</u>				22e. REC'D BY REGISTRAR <u>Charles Judge</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>6-1-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter & Paul Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Cumberland, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc Baltimore, Md.</u>				25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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[Faint, mostly illegible text and markings covering the main body of the document, possibly a form or report.]

UNITED STATES GOVERNMENT
OFFICE OF THE SECRETARY OF DEFENSE

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
Item 3 Film G 388 5/10/67

CERTIFICATE OF DEATH

06228

1. PLACE OF DEATH a. COUNTY <i>Ba. Co.</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Summit Nursing Home</i>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i> Md.</i> b. COUNTY <i>Anne Arundel</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pasadena</i> d. STREET ADDRESS <i>Rt 2 - Boy 266 St.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Gloyd Clyde T. Cook</i>				4. DATE OF DEATH Month Day Year <i>May 5, 1967</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>6-14-90</i>	
10a. USUA OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Gen Elec</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Leodore</i>				14. MOTHER'S MAIDEN NAME <i>Frances Boyle</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <i>Family - Same</i> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1810 Pulmonary Infection</i> DUE TO (b) <i>Lung Tumor (Metastasis)</i> DUE TO (c) <i>Bladder malignancy</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs</i> <i>8 months</i> <i>1 1/2 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>3/1/67</i> to <i>5/5/67</i> that (I) (we) last saw the deceased alive on <i>5/1/67</i> , and that death occurred at <i>12:30 P.M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>Wm. Lawrence J. Ratliff, Sr.</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>5/5/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>CLIFFE RATLIFF, SR.</i>				22d. ADDRESS <i>4605 EDMONDSON AVE #22</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>5/8/67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Green Haven</i>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>McCoy - 737</i> ADDRESS <i>Catonsville</i>				25a. REC'D BY REGISTRAR <i>DA MAY 8 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards and papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06238

CERTIFICATE OF DEATH

06229

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>		d. STREET ADDRESS <u>321 Oaklee Village - Z-29</u>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Ellen</u> Last <u>Coppinger</u>		4. DATE OF DEATH Month <u>5</u> Day <u>1</u> Year <u>19 67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-09-02</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		9b. AGE (In years last birthday) <u>64</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>IRELAND</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>IRELAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>PATRICK KERRIGAN Kerrigan</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET CARTY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>WILLIAM COPPINGER</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>HOURS</u> <u>FEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-28, 19 67</u> to <u>5-1, 19 67</u> that (I) (we) last saw the deceased alive on <u>5-1, 19 67</u> , and that death occurred at <u>10:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Rolando Vieta</u>		22b. DATE SIGNED <u>5-1-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROLANDO VIETA</u>		22d. ADDRESS <u>Spring Grove State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-5-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Avenue 21229</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 3 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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U.S. AIR FORCE
OFFICE OF THE
JOINT CHIEFS OF STAFF
WASHINGTON, D.C.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06233

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06230

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
c. LENGTH OF STAY IN TB 1 Hour		d. STREET ADDRESS 1616 Dogwood Hill Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sarah Long Cornthwaite		4. DATE OF DEATH Month May Day 7 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/14/24
9. AGE (In years last birthday) 40 yrs.		10. IF UNDER 1 YEAR Months 4 Days 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guidance counselor		10b. KIND OF BUSINESS OR INDUSTRY School	
11. BIRTHPLACE (State or foreign country) Ocala, Fla.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Long		14. MOTHER'S MAIDEN NAME Evlyn Moon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 262-26-3232	
17. INFORMANT Mr. David L. Cornthwaite		Address 1616 Dogwood Hill	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Occlusion DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.		22. DATE SIGNED 5/7/67 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/10/67	23c. NAME OF CEMETERY OR CREMATORY Friends Burial Grounds Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson		25a. REC'D BY REGISTRAR DATE MAY 10 1967 25b. REGISTRAR'S SIGNATURE Richard J. Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06240

CERTIFICATE OF DEATH

06231

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY in 1b 19 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle HARVEY Last CRESS				4. DATE OF DEATH Month MAY Day 14 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/15/86		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Congoleum-Nairn Inc.		11. BIRTHPLACE (County & State, or foreign country) Carrollton, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Cress				14. MOTHER'S MAIDEN NAME Mary Lou Dutrow			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 216-07-42-25		17. INFORMANT Address Clin. Rec. VA Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 491X DOXOX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. x PULX (b) PULMONARY INFARCTION, MULTIPLE, BILATERAL (c) ARTERIOSCLEROTIC HEART DISEASE WITH CONGESTIVE FAILURE old						INTERVAL BETWEEN ONSET AND DEATH RECENT	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PARKINSON DISEASE, OLD						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (A) (this hospital) attended the deceased from April 25 , 19 67 , to May 14 , 19 67 that (A) (we) last saw the deceased alive on May 14 , 19 67 , and that death occurred at 1:10 PM from causes and on the date stated above.							
22a. SIGNATURE <i>DeCastro</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/15/67	
22c. PHYSICIAN'S NAME (Type) RAUL F. DeCASTRO, M. D.				22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/17/67		23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		23d. LOCATION (City or Town) (County) (State) Westminster, Carroll, Md.	
24. FUNERAL DIRECTOR J. S. Myers Jr. Myers Funeral Home		ADDRESS Longwell Avenue Westminster, Md.		25a. REC'D BY REGISTRAR MAY 18 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

18320

00330

CERTIFICATE OF DEATH

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Manner of death

8. Signature of physician

9. Signature of registrar

10. Date of registration

11. Place of registration

12. Signature of informant

13. Signature of witness

14. Signature of registrar

15. Date of registration

16. Place of registration

17. Signature of informant

18. Signature of witness

19. Signature of registrar

20. Date of registration

21. Place of registration

22. Signature of informant

23. Signature of witness

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in the space provided. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. Other pages along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06241

06232

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sweetair</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baldwin</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>Baldwin Mill Rd. Box 181</u>			
3. NAME OF DECEASED (Type or print) First <u>REGINA</u> Middle <u>ANN</u> Last <u>DALTON</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>16</u> Year <u>19 67</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/27/1945</u>		9. AGE (In years lost birthday) yrs. <u>22</u>	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William M. Dalton</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude R. Riley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. William M. Dalton- Same</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing Injury to Skull</u> 8234 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple Body Fractures</u> DUE TO (c) <u>RT Femur Fracture</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Seconds</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY CAUSE OF CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Striking Auto that Ran off Road & Struck Bldg</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>9</u> p.m. <u>May 16 1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Sweetair Baltimore Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>		EXAMINER'S NAME (Type) <u>CHARLES F. O'DONNELL, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>5/16/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/19/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Long Green Balto. Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. 5305 Harford Rd. #14</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06242

06233

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 16			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER				d. STREET ADDRESS 713 Carolyn Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AUGUSTA Middle Last DANGO				4. DATE OF DEATH Month May Day 17 , Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-10-1893	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown - Huffins				14. MOTHER'S MAIDEN NAME Helen Kresh			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 215-01-3179		17. INFORMANT Address Mrs. Elsie E. Bensinger, 713 Carolyn Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest secondary to old + DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) probably acute infarction DUE TO (c) Diabetic Mellitus							INTERVAL BETWEEN ONSET AND DEATH 8 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 11 , 19 67 , to May 17 , 19 67 , that (I) (we) lost saw the deceased alive on May 17 , 19 67 , and that death occurred at 10:45 A.M. from causes and on the date stated above.							
22a. SIGNATURE Ludilina M. Opeyza				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/17/67	
22c. PHYSICIAN'S NAME (Type) LUDILINA M. OPEYZA				22d. ADDRESS GBMC- 6701 N. Charles St. MD. 21004			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-20-1967		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Avenue 21229				25a. REC'D BY REGISTRAR DATE MAY 22 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06243

CERTIFICATE OF DEATH

06234

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 364 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DEWEY Middle J. Last DANIEL		4. DATE OF DEATH Month MAY Day 2 Year 19 67	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/23/98
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PIPEFITTER		10b. KIND OF BUSINESS OR INDUSTRY SHIP BUILDING	
11. BIRTHPLACE (County & State, or foreign country) WELDON, NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ELISHA DANIEL		14. MOTHER'S MAIDEN NAME MARY ASH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 218 01 57 71	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1991X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ENCEPHALOMALACIA AND GENERALIZED ARTERIOSCLEROSIS		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from 5/3/66 , 19__, to 5/2/67 , 19__, that the (we) last saw the deceased alive on 5/2/67 , 19__, and that death occurred at 2:00 PM , from causes and on the date stated above.			
22a. SIGNATURE J. D. Talbert		22b. DATE SIGNED 5/2/67	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5-5-67	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR MORTEN & DYETT FUNERAL HOME		25. REGISTRAR'S SIGNATURE Charles Judge	

ADDRESS
1701 LAURENS ST BALTIMORE, MD 4

25b. REGISTRAR'S SIGNATURE
1967

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06244

CERTIFICATE OF DEATH

06235

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chesapeake Manor Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium d. STREET ADDRESS 205 Patann Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT L. DAVIS First Middle Last		4. DATE OF DEATH Month May Day 5 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-29-1893
9. AGE (In years last birthday) 73 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. County Commissioner	11. BIRTHPLACE (County & State, or foreign country) Penna.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Harry C. Davis	
14. MOTHER'S MAIDEN NAME Catherine		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. 207123654A		17. INFORMANT Address Mrs. George Bell, 205 Patann Rd, Timonium-21093	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Colon with metastasis 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 27, 1967 , to May 5, 1967 , that (I) (we) last saw the deceased alive on May 5, 1967 , and that death occurred at 9:42 P.M. from causes and on the date stated above.			
22a. SIGNATURE A. Allan Spier		22b. DATE SIGNED 5/6/67	
22c. PHYSICIAN'S NAME (Type) Dr. A. Allan Spier		22d. ADDRESS 1501 Pentridge Rd, Balto, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation	23b. DATE THEREOF May 6, 1967	23c. NAME OF CEMETERY OR CREMATORY Greenmount	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc.-Baltimore, Md. - 14		25a. REC'D BY REGISTRAR MAY 8 1967	
		25b. REGISTRAR'S SIGNATURE Charles Young	

10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

<p>1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE c. LENGTH OF STAY IN 1b 1 mo. 10d.</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL</p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE</p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson d. STREET ADDRESS 1610 Lyle Court</p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) First ROSA Middle MAUDE Last DAVIS</p> <p>4. DATE OF DEATH Month MAY Day 29 Year 1967</p>		<p>5. SEX F 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p> <p>8. DATE OF BIRTH 3-17-90 9. AGE (In years last birthday) 77 yrs. IF UNDER 1 YEAR Months 2 Days 12 IF UNDER 24 HRS. Hours Min. </p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE</p> <p>10b. KIND OF BUSINESS OR INDUSTRY </p>		<p>11. BIRTHPLACE (County & State, or foreign country) SOUTH CAROLINA</p> <p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>	
<p>13. FATHER'S NAME Thos. Lewis</p>		<p>14. MOTHER'S MAIDEN NAME Addis</p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) </p>		<p>16. SOCIAL SECURITY NO. 219-01-3009</p>	
<p>17. INFORMANT CARSON W. CLEGG, JR. Address 1610 LYLE COURT</p>		<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO (b) PNEUMONIA DUE TO (c) ETIOLOGY UNKNOWN</p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS</p>		<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>	
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. </p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>	
<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from APRIL 19, 1967 to MAY 29, 1967, that (I) (we) last saw the deceased alive on APRIL 19, 1967, and that death occurred at 3:59 PM, from the causes and on the date stated above.</p>			
<p>22a. SIGNATURE Morris Meiller</p>		<p>22b. DATE SIGNED 5/29/67</p>	
<p>22c. PHYSICIAN'S NAME (Type) MORRIS MEILLER, M.D.</p>		<p>22d. ADDRESS SPRING GROVE STATE HOSPITAL</p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) B</p>		<p>23b. DATE THEREOF 5/29/67</p>	
<p>23c. NAME OF CEMETERY OR CREMATORY London V.A. Bn.</p>		<p>23d. LOCATION (City, town or county) (State) Baltimore</p>	
<p>24. FUNERAL DIRECTOR McCully - 237 ADDRESS Catonsville Ave.</p>		<p>25a. REC'D BY REGISTRAR MAY 31 1967 25b. REGISTRAR'S SIGNATURE Charles Judge</p>	

1992

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MD
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06246

CERTIFICATE OF DEATH

06237

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MD. b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		d. STREET ADDRESS 119E WASHINGTON ST.	
3. NAME OF DECEASED (Type or print) First LAWRENCE Middle BERNARD Last DEE		4. DATE OF DEATH Month MAY Day 8 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-15-1906
9. AGE (In years lost birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (County & State, or foreign country) MASS.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME DECLAN DEE		14. MOTHER'S MAIDEN NAME ELLEN FLYNN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. 207-09-1046	
17. INFORMANT Records, Mount Wilson State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5272 Congestive heart failure DUE TO (b) Obstructive AIRWAYS disease DUE TO (c) years		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0021 FAR ADV. PULMONARY TUBERCULOSIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE Newcomer		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF May 12, 1967	23c. NAME OF CEMETERY OR CREMATORY New Catholic Cemetery Baltimore, Md.	23d. LOCATION (City or town) (County) (State)
24. FUNERAL DIRECTOR New Funeral Home Parkville - 524		25. MAY 15 1967 DATE	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06247

06238

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore			
c. LENGTH OF STAY IN 1b 20 Yrs.				d. STREET ADDRESS 206 N. Tyron e Rd.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 206 Tyrone Rd. N. 21212				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JESSIE LOUISE DEFIBAUGH				4. DATE OF DEATH Month Day Year May 24, 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 24, 1880	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (County & State, or foreign country) Uniontown, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Doran				14. MOTHER'S MAIDEN NAME Amanda Cup			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-07-1922D		17. INFORMANT Address Mrs. Helen D. Krause-206 Tyrone Rd. N. 21212			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) 4331 ASCVD with a final fibrillation DUE TO Peripheral arterial Occlusion with Gangrene Right Hand Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Mass in abdomen (etiology)				INTERVAL BETWEEN ONSET AND DEATH 4 weeks 1 week			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) was attended the deceased from Sept. 1958 to May 1967 , that (I) was last saw the deceased alive on 23 May 1967 and that death occurred at 12 M. from the causes and on the date stated above.							
22a. SIGNATURE Wm. H. Kammer, Jr.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/24/67	
22c. PHYSICIAN'S NAME (Type) Wm. H. Kammer, Jr.				22d. ADDRESS 6011 York Rd. Balto. Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/27/67		23c. NAME OF CEMETERY OR CREMATORY Hill Crest Burial Pk.		23d. LOCATION (City, town or county) (State) Cumberland Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE H. Wayne George George Funeral Home - Cumberland, Md.				25a. REC'D BY REGISTRAR MAY 29 1967		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician.
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TOMAS HALL

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1. *Chrysomelidae* (Colorado potato beetle)
 2. *Chrysomelidae* (Colorado potato beetle)
 3. *Chrysomelidae* (Colorado potato beetle)

There is no doubt that the

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[Faint handwritten signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06248

CERTIFICATE OF DEATH

06239

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) College Manor Nursing Home				d. STREET ADDRESS 3401 N. Charles St. 21218			
3. NAME OF DECEASED (Type or print) First Mary Middle Boykin Last Dell				4. DATE OF DEATH Month May Day 19 Year 1967			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10/14/1875	9. AGE (In years lost birthday) 91 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Norfolk, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William A. Boykin				14. MOTHER'S MAIDEN NAME Elizabeth Whitehead Irwin			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-54-6188		17. INFORMANT Bernard Boykin, 1919 Ruxton Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senility, Arteriosclerosis, with 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Spinal cord complications DUE TO (c) Terminal Lobar Pneumonia						INTERVAL BETWEEN ONSET AND DEATH 29 years 2 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/5/1938 to 5/19/1967 , that (I) (we) last saw the deceased alive on 5/18/1967 , and that death occurred at 4:57 A.M. from causes and on the date stated above.							
22a. SIGNATURE M.B. Levin		22b. DATE SIGNED 5/19/67		22c. PHYSICIAN'S NAME (Type) Dr. M. B. Levin			
22d. ADDRESS 218 E. University Pkwy.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Rem. Burial		23b. DATE THEREOF 5/24/1967		23c. NAME OF CEMETERY OR CREMATORY Cedar Grove		23d. LOCATION (City or Town) (County) (State) Norfolk Va.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.				25a. REC'D BY REGISTRAR MAY 22 1967		25b. REGISTRAR'S SIGNATURE J. Charles Jones	

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2332

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C.

RECEIVED

SEP 10 1954

TO THE HONORABLE CHIEF JUSTICE

AND THE HONORABLE JUSTICES

OF THE SUPREME COURT

WASHINGTON, D. C.

FROM THE ATTORNEY GENERAL

RE: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

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[illegible]

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06249

CERTIFICATE OF DEATH

06240

1. PLACE OF DEATH COUNTY Baltimore MIDDLE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1101 Kenilworth Drive 21204	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Annie First L. Middle De Prine Last		4. DATE OF DEATH Month 5 Day 5 Year 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/13/1889
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Bauer		14. MOTHER'S MAIDEN NAME Marian D. Ellicot	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 212 12 1661	
17. INFORMANT D. Mr. John L. DePrine		Address 1101 Kenilworth Drive.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Cerebral Arteriosclerosis with recent Cerebral DUE TO (c) Thrombosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/11 , 19 67 , to 5/5 , 19 67 , that (I) (we) last saw the deceased alive on 5/5 , 19 67 , and that death occurred at 3:50p M, from causes and on the date stated above.			
22a. SIGNATURE Efraim L. R. eyes M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Efraim L. R. eyes		22d. ADDRESS St. Joseph Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/9/67	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR HENRY SANDER & SONS INC. BALTIMORE MD.		25a. REC'D BY REGISTRAR MAY 8 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
06250 CERTIFICATE OF DEATH 06241

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 20 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summit Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Merridale d. STREET ADDRESS 632 Plymouth Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rudolph Middle H. Last Dienhart		4. DATE OF DEATH Month May Day 9 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 16, 1884
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Transportation Clerk		10b. KIND OF BUSINESS OR INDUSTRY B. & O. R.R.	
11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Julius J. Dienhart		14. MOTHER'S MAIDEN NAME Augusta E. Ehoff	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. George E. Russell, Jr.		Address 179 Southview Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio-Vascular Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			INTERVAL BETWEEN ONSET AND DEATH 15 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) this hospital attended the deceased from Nov. , 19 51 , to May , 19 67 , that (I) was last saw the deceased alive on May 6 , 19 67 , and that death occurred at 4:25 PM , from the causes and on the date stated above.			
22a. SIGNATURE Leo J. Gaer		22b. DATE SIGNED May 10, 1967	
22c. PHYSICIAN'S NAME (Type) Leo J. Gaer		22d. ADDRESS 1 Mallow Hill Ave., Baltimore, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-12-1967	23c. NAME OF CEMETERY OR CREMATORY Loudon Park	23d. LOCATION (City, town or county) (State) Baltimore, Md.
24. FUNERAL DIRECTOR G. Howard Strong		25a. REC'D BY REGISTRAR 11 1967	
ADDRESS 3207 W. North Ave.,		25b. REGISTRAR'S SIGNATURE Charles J. Jones	

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FOR STATE
HEALTH DEPT.

is necessary, if any, to the funeral director, Page 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
06251 06242											
1. PLACE OF DEATH a. COUNTY <i>Balto</i>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>				c. LENGTH OF STAY IN 1b <i>life</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>St Joseph's Hosp. Towson</i>				d. STREET ADDRESS <i>1654 E. Belvedere</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>FREDERICK</i>				4. DATE OF DEATH <i>May 28 1967</i>				5. SEX <i>Male</i>			
6. COLOR OR RACE <i>W.</i>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <i>Dec 19 1897</i>			
9. AGE (In years last birthday) <i>69</i>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ice Plant Employee</i>				11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				13. FATHER'S NAME <i>Henry Dietz</i>				14. MOTHER'S MAIDEN NAME <i>Wilhelmina Spelman</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>212-12-0683A</i>				17. INFORMANT <i>Mrs Louise Roth</i> Address <i>1654 E. Belvedere Avenue</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive Arteriosclerotic Cardiovascular Disease</i> 443X											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Due to</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.											
20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <i>Natural causes</i> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Frank T. Kasik MD</i> CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
EXAMINER'S NAME (Type) <i>FRANK T. KASIK MD</i> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>9005 HARTFORD RD.</i> Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>											
22b. DATE THEREOF <i>5-31-1967</i>											
22c. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith Cemetery</i>											
22d. LOCATION (City, town, or country) (State) <i>Baltimore Co. Md.</i>											
23. FUNERAL DIRECTOR <i>Lassahn Funeral Home</i> ADDRESS <i>7401 Belair Road</i>											
24a. REC'D BY REGISTRAR <i>(36)</i>											
24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>											
DATE <i>MAY 31 1967</i>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06252

CERTIFICATE OF DEATH

06243

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 15 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234 d. STREET ADDRESS 8007 Jacqueline Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Lucille Last DiFATTA		4. DATE OF DEATH Month May Day 16 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 8, 1923
9. AGE (In years last birthday) 44 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker	11. BIRTHPLACE (County & State, or foreign country) West Virginia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Benjamin J Rowland	
14. MOTHER'S MAIDEN NAME Madge Ramsey		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. 170X		17. INFORMANT Family Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of the breast DUE TO (b) Pyelonephritis DUE TO (c) Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 28, 19 67 , to May 16, 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 16, 19 67 , and that death occurred at 7:45 AM , from causes and on the date stated above.			
22a. SIGNATURE Miles E. St. John		22b. DATE SIGNED May 16, 1967	
22c. PHYSICIAN'S NAME (Type) Miles St. John, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5/18/67	23c. NAME OF CEMETERY OR CREMATORY Parkwood	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR CHAS. F. EVANS & SON, INC Balto. Md.		25a. REC'D BY REGISTRAR MAY 18 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06253		Item #2a, b, c & d info, taken from prev. birth cert.				06207			
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>					c. LENGTH OF STAY IN 1b <u>Baltimore</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Balto. Medical Center</u>					d. STREET ADDRESS <u>804 Apt. H Wilson Point Road</u>				
3. NAME OF DECEASED (Type or print) <u>Baby Boy Diggins</u>					4. DATE OF DEATH <u>May 7 1967</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-7-67</u>		9. AGE (In years, last birthday) <u>6</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min <u>39</u>	
10a. MALE OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>					12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME <u>MARVIN PAUL Diggins</u>					14. MOTHER'S MAIDEN NAME <u>NANCY JOAN HARNER</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. <u>Infant Birth information sheet</u>		17. INFORMANT Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY WITH PRIMARY APNOEA.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>7695</u> DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>POSSIBLE TRISOMY 16-18</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>5-7-</u> , 19 <u>67</u> , to <u>5-7-</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-7-1967</u> 19 <u>67</u> , and that death occurred at <u>8:40 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>E. K. S. Narayanan</u> M.D.					22b. DATE SIGNED <u>5-7-1967</u>				
22c. PHYSICIAN'S NAME (Type) <u>E. K. S. NARAYANAN</u>					22d. ADDRESS <u>INTERN, GREATER BALTO-MED. CENTER</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <u>5/8/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greater Balto. Med. Ctr. Towson & Md.</u>		23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR <u>John E. Adams, M.D. ABULLC.</u>					25a. REC'D BY REGISTRAR <u>MAY 10 1967</u> 25b. REGISTRAR'S SIGNATURE <u>John E. Adams</u>				

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[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "THERMIST" and "TEMPERATURE" are faintly visible.]

05/07 Center Tech. School - Towns & Sub
P.O. Box 1111, Adams, MD. 20806

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

06254

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06244

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upperco P O		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upperco P O	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dark Hollow Road		d. STREET ADDRESS Dark Hollow Road	
3. NAME OF DECEASED (Type or print) First Middle Last ANDREW Andrew DIGGS		4. DATE OF DEATH Month Day Year May 20 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10, 1894
9. AGE (In years last birthday) yrs. 73		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Unknown Diggs		14. MOTHER'S MAIDEN NAME Annie Tucker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-24-7890 A	
17. INFORMANT Mrs. Grace Thomas		Address Baltimore, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive and arteriosclerotic 443 X DUE TO cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute bronchopneumonia		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED May 21, 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 24, 1967	
23c. NAME OF CEMETERY OR CREMATORY Piney Grove		23d. LOCATION (City or Town) (County) (State) Boring Md.	
24. FUNERAL DIRECTOR J. F. Eline & Sons ADDRESS Reisterstown, Md.		25a. REC'D BY REGISTRAR MAY 25 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06255

06245

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Summit Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGEWATER</u> d. STREET ADDRESS <u>R2 Box 29</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ELSIE I. DOOLAN</u> First Middle Last SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>SEPT 1 1899</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				4. DATE OF DEATH <u>MAY 10 1967</u> Month Day Year			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WASH. DC.</u> 12. CITIZEN OF WHAT COUNTRY? <u>US.</u>		13. FATHER'S NAME <u>HERBERT GORDON</u> 14. MOTHER'S MAIDEN NAME <u>EFFIE WASHINGTON WRIGHT</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> 16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>MRS. THORN #2</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis left</u> (b) <u>Diabetes Mellitus</u> (c) <u>Emphysema Pulmonary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Arteriosclerotic Cardiovascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Stroke</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				INTERVAL BETWEEN ONSET AND DEATH <u>40 days</u> <u>5 years</u> <u>5 years</u> <u>5 years</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>4/18/67</u> to <u>5/10/67</u> , that (I) (we) last saw the deceased alive on <u>5/9/67</u> , and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>W E Mc Grath</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>W E Mc Grath</u>				22b. DATE SIGNED <u>5/11/67</u> 22d. ADDRESS <u>1303 Frederick Rd Catonsville 28 Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>MAY 12 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CREM.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm M. Taylor</u>		ADDRESS <u>SON ANNAPOLIS MD.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
25b. REGISTRAR'S SIGNATURE		DATE <u>MAY 15 1967</u>					

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

John M. Taylor, San Francisco MD

Examination May 12 1897 Test Lincoln Creek, Prince Georges Co. MD

2/18/97

Received of the
Treasurer of the
Board of Directors
of the
Maryland
State
Police
the sum of
\$100.00
for
the
year
1896

Mrs. Thoen

HERBERT GORDON
Home Wash DC
3732 Washington Wright
AS

Female White

Elsie

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Doonan

MAY 10 1897

Summit Nursing Home R2 Box 29

EDGEWATER

CATONSVILLE

Baltimore

Maryland

1897

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/62

FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item #9 Film #G389 6/5/67 ps											
06256 06246											
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE 12						c. LENGTH OF STAY IN lb TIMONIUM					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) REGISTER AVE. DORLING RD.											
3. NAME OF DECEASED (Type or print) FRANK P DUNLAP						4. DATE OF DEATH Month MAY Day 27 Year 1967					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-16-02		9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) pol course super.											
10b. KIND OF BUSINESS OR INDUSTRY Balto. Country Club						11. BIRTHPLACE (State or foreign country) Ohio			12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME unknown dec'd						14. MOTHER'S MAIDEN NAME unknown dec'd					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no none						16. SOCIAL SECURITY NO. V78-07-9552			17. INFORMANT Family records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4201 DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF 5/31/67					
22c. NAME OF CEMETERY OR CREMATORY Mays Chapel Cemetery						22d. LOCATION (City, town, or country) (State) Timonium, Balto. Co. Md.					
23. FUNERAL DIRECTOR John Burns Sons 610-12 York Rd. Towson 21204						24a. REC'D BY REGISTRAR Charles Judge					
24b. REGISTRAR'S SIGNATURE Charles Judge						DATE MAY 29 1967					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06257

CERTIFICATE OF DEATH

06247

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. LENGTH OF STAY IN 1b 21403			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thomas Middle NMN Last Early				4. DATE OF DEATH Month 5 Day 20 Year 1967			
5. SEX Male	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-03-03	9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months 6 Days 17 Hours 11 Min.		11. IF UNDER 24 HRS. Hours 11 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Foreman				10b. KIND OF BUSINESS OR INDUSTRY Retail Dairy		11. BIRTHPLACE (County & State, or foreign country) ROGERSVILLE TENN.	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME JAMES EARLY (DECEASED)			
14. MOTHER'S MAIDEN NAME Mandy STUBBLEFIELD				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN			
16. SOCIAL SECURITY NO. 408-28-488				17. INFORMANT Lula B. Early - same as #2 above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-9-67 to 5/20/67 , that (I) (we) last saw the deceased alive on 5/20/67 , and that death occurred at 5/20/67 M, from causes and on the date stated above.							
22a. SIGNATURE R. K. CHILLAR				22b. DATE SIGNED 5/20/67		22c. PHYSICIAN'S NAME (Type) RAM K. CHILLAR	
22d. ADDRESS ATT. BALTO. MED. CENTER				22e. REC'D BY REGISTRAR MAY 24 1967			
22f. REGISTRAR'S SIGNATURE Charles Judge				23. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5/23/67			
23c. LOCATION (City or Town) (County) (State) Annapolis Md.				24. FUNERAL DIRECTOR Beverley E. Hopping			
24a. ADDRESS Hopping Funeral Home - Annapolis, Md.				24b. REGISTRAR'S SIGNATURE Charles Judge			

06252

Baltimore

Male CAR
Thomas J. Early
Greater Baltimore Medical Center

Ca lung

Ram K. Chhillar
J. Chhillar

2-2-67
2-2-67
ATC. BALTO. MED. CENTER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06258

CERTIFICATE OF DEATH

06248

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> <u>03-1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUMMIT HOME</u>				d. STREET ADDRESS <u>2119 ARLOHNE DR.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>REA HOOPER EDGAR SR.</u> First Middle Last				4. DATE OF DEATH <u>MAY 13</u> 19 <u>67</u> Month Day Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/22/91</u>		9. AGE (In years lost birthday) yrs. <u>75</u>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETI.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>WILLIAM EDGAR</u>				14. MOTHER'S MAIDEN NAME <u>MAMIE REA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212 10 6420</u>		17. INFORMANT Address <u>HELEN EDELMANN</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia due to</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerotic coronary disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>67</u> , to <u>13 May</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>13 May</u> 19 <u>67</u> , and that death occurred at <u>7</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>William J. Bryson</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>15 May 67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5/16/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO. CO. MD</u>	
24. FUNERAL DIRECTOR <u>E.S. MALNABB JR.</u>				25a. REC'D BY REGISTRAR <u>MAY 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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WAGO

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06253

06249

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN TB 30.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hillendale Country Club		d. STREET ADDRESS 1202 Cherry Hill Road	
3. NAME OF DECEASED (Type or print) First WILL Middle LEONARD Last ELLERBE		4. DATE OF DEATH Month May Day 11 Year 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-14-1926
9. AGE (In years last birthday) 41 yrs.		10. IF UNDER 1 YEAR Months 4 Days 19 Hours 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR		10b. KIND OF BUSINESS OR INDUSTRY CONST.	
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joshua Ellerbe		14. MOTHER'S MAIDEN NAME MINNIE HINES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Lydia Ellerbe		Address 1202 Cherry Hill Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive and Arteriosclerotic Cardiovascular Disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) 4431 (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty M.D.		22. DATE SIGNED 5/11/67	
EXAMINER'S NAME (Type) Charles S. Petty		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5/16/67	23c. NAME OF CEMETERY OR CREMATORY Corver Mem. Park Laurel Md.	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR Milton E. Elisham		25a. REC'D BY REGISTRAR MAI 12 1967 DATE	
25b. REGISTRAR'S SIGNATURE Charles Judge			

41330

41330

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11/10/50

2-11-1950

Ellebe, H. S.
Mines, Texas

Ellebe, H. S.
Mines, Texas

Ellebe, H. S.
Mines, Texas

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Ellebe, H. S.
Mines, Texas

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 4 Film 6389 5/29/67 kk

06260

CERTIFICATE OF DEATH

06250

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LUTHERVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LUTHERVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>16 E. SEMINARY AVE.</u>		d. STREET ADDRESS <u>16 E. SEMINARY AVE.</u>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>E.</u> Last <u>ENDERS</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 1-1895</u>
9. AGE (In years lost birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Wells - (Step Father)</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta E. Wells</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Family Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction</u> DUE TO (b) <u>200X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Diabetes & Arteriosclerosis C.V. Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Severe Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Coronary Thrombosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>many years</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>Apr 24</u> 19 <u>67</u> , and that death occurred at <u> </u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>George McLean</u>		22b. DATE SIGNED <u>5/4/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>GEORGE McLEAN</u>		22d. ADDRESS <u>705 Med Arts Bldg</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY 5, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Towson, Md.</u>	
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Md.</u>		25. REC'D BY REGISTRAR <u>MAY 8 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

08380

08380

MAY 1961

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06251

06261

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE-RIVER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE-RIVER</u>	
c. LENGTH OF STAY IN 1b <u>30 YRS.</u>		d. STREET ADDRESS <u>2200 Old OREMS Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2200 Old OREMS Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HARRY CHARLES EVANS SR</u>		4. DATE OF DEATH <u>MAY 10 1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-6-1894</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER-RET</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CO</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>HARRY C EVANS</u>		14. MOTHER'S MAIDEN NAME <u>WERNER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>216-10-6063A</u>	
17. INFORMANT <u>Florence Evans</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary Occlusion</u> DUE TO (b) <u>A-S-C-V-Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M.B. Davis</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. DAVIS MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5/13/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD Cem.</u>		23d. LOCATION (City or town) (County) (State) <u>BALTO MD.</u>	
24. FUNERAL DIRECTOR <u>J. G. CONNELLY SONS</u>		25a. REC'D BY REGISTRAR <u>Essex</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		22. DATE SIGNED <u>5/11/67</u>	

00001

UNITED STATES DEPARTMENT OF JUSTICE

00001

IN RE: [illegible]

NO. [illegible]

FILED [illegible]

AT [illegible]

IN THE [illegible]

COURT OF [illegible]

THE [illegible]

STATE OF [illegible]

VS. [illegible]

[illegible]

[illegible]

[illegible]

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[illegible]

[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06262

06252

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 14 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph, Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE M Virginia b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halifax d. STREET ADDRESS Rt #1, Box 568 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANNIE Middle MAUDE Last FARMER			4. DATE OF DEATH Month May Day 26 Year 19 67				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-26-94	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Virginia		11. BIRTHPLACE (County & State, or foreign country) U.S.A.			
13. FATHER'S NAME Lee Divers			14. MOTHER'S MAIDEN NAME Martha Dillon				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Address H. Melvin Farmer 1410 Tenbury Rd. 21903			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 332X IMMEDIATE CAUSE (a) Cerebro vascular thrombosis, right cerebral artery DUE TO (b) Possible pulmonary embolism and infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 5-12 , 1967 to 5-26 , 1967 , that (I) (we) last saw the deceased alive on 5-26 , 1967 , and that death occurred 4:35 P , from causes on and on the date stated above.					
22a. SIGNATURE <i>Fiorella G. Malit</i>			22b. DATE SIGNED 5-26-67		22c. PHYSICIAN'S NAME (Type) Fiorella G. Malit, M.D.		
22d. ADDRESS 7620 York Road, Baltimore, Md. 21204			22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/29/67		23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cemetery			
23d. LOCATION (City or Town) (County) (State) Halifax, Va.		24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson 1050 York Rd. 21204					
25a. REC'D BY REGISTRAR DATE MAY 29 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06263

CERTIFICATE OF DEATH

06253

Item 2 Form 6389 5/1/67

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Baltimore</u> Maryland b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4400 Hill/ Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>10 MONTHS</u>		30.4	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SHANGRI-LA NURSING HOME</u>		d. STREET ADDRESS <u>2279 Park Hill Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		383 HARLEM AVE	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>FAUBLE</u> Last <u>FAUBLE</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>2/27/1888</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>UNKNOWN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>UNKNOWN John Redlin</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN Annie Kline</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>W. D.123-038</u>	
17. INFORMANT <u>Linthicum, Md.</u> Address <u>Mr. Melvin F. Fauble 516 Springer Court</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral due to Renal failure.</u> DUE TO <u>441X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malignant gly pertum.</u> DUE TO (c) <u>AS/VID e Renal Cunnig.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus. Hypertension.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/26</u> , 19 <u>66</u> , to <u>5/4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/4/67</u> , 19 <u>—</u> , and that death occurred at <u>11:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Arnstmo M. Allis</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/4/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Arnstmo M. Allis 690</u>		22d. ADDRESS <u>8155 Loch Raven Blvd.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>May 6, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto. Md.</u>
24. FUNERAL DIRECTOR <u>G. Truman Schwab 3512 Frederick Ave, Balto. Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 8 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02353

STATE OF MICHIGAN

02353

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RECEIVED
JUL 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06264

06254

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center			d. STREET ADDRESS 7524 Belair Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH FRANK FAULSTICH			4. DATE OF DEATH Month Day Year May 16 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3/20/16		9. AGE (In years lost birthday) 51 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Technician		10b. KIND OF BUSINESS OR INDUSTRY Maritime Adminis.		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Henry Faulstich			14. MOTHER'S MAIDEN NAME Steidle Caroline		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-05-5260		17. INFORMANT Patient's Chart Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4221 IMMEDIATE CAUSE (a) Cardiorespiratory failure due to DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) 					INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 5/9/ , 1967, to 5/16 , 1967, that (I) (we) last saw the deceased alive on 5/16 , 1967, and that death occurred at 9:27AM , from causes on and on the date stated above.					
22a. SIGNATURE <i>John E. Adams</i>			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED May 16, 1967
22c. PHYSICIAN'S NAME (Type) Daniel F. Negrete			22d. ADDRESS Greater Baltimore Medical Center		
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE THEREOF May 14, 1967		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
23d. LOCATION (City or Town) Taylor Avenue		(County) Balto		(State) Md.	
24. FUNERAL DIRECTOR DIPPEL BROS INC 7110 BELAIR ROAD			25a. REC'D BY REGISTRAR MAY 18 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06265

CERTIFICATE OF DEATH

06255

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverview				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 914 Winsap Court, Riverview, Md. 21227				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle J. Last Faulstich				4. DATE OF DEATH Month May Day 12 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/16/92		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter			10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Faulstich				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 213-05-5091		17. INFORMANT Mrs. Herma C. Parsons Address 914 Winsap Court		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Generalized Carcinoma from Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Large Bowel (c) Large Bowel							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan. 30, 1967 , to May 12, 1967 , that (I) (we) last saw the deceased alive on May 12, 1967 , and that death occurred at 8:00 A.M. , from causes and on the date stated above.							
22a. SIGNATURE D. Sorongon					22b. DATE SIGNED 5/13/67		
22c. PHYSICIAN'S NAME (Type) DOMINGO C. SORONGON, M.D.					22d. ADDRESS 3915 HOLLINS FERRY RD. BALTO., Md. 21227		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/15/67		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Howard H. Hubbard				25a. REC'D BY REGISTRAR 4107 Wilkens Ave. 21229		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE MAY 15 1967							

00222

00222

THE STATE DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
REPORT OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF BIRTH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
OCCUPATION: [illegible]
EDUCATION: [illegible]
RELIGION: [illegible]
MARRIAGE: [illegible]
SINGLE: [illegible]
MARRIED: [illegible]
DIVORCED: [illegible]
WIDOWED: [illegible]
MILITARY SERVICE: [illegible]
NAVY: [illegible]
ARMY: [illegible]
AIR FORCE: [illegible]
MARINE CORPS: [illegible]
COAST GUARD: [illegible]
OTHER: [illegible]
SIGNED: [illegible]
DATE: [illegible]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06266

06256

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethlehem Steel Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE 820 Belnord Ave b. COUNTY 21224 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Md d. STREET ADDRESS Sparrows Point Md e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Leo B Filipiak		4. DATE OF DEATH Month May Day 6 Year 1967 19	
5. SEX M/W	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 22 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roll Shop Helper		10b. KIND OF BUSINESS OR INDUSTRY Steel	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stefan		14. MOTHER'S MAIDEN NAME Josephine Benger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213 07 7070	
17. INFORMANT Mrs. Florence Filipiak		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) A-S-C-V. Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None			INTERVAL BETWEEN ONSET AND DEATH —
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M B Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, County, State) Charles Judge	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5 11 67	23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus	23d. LOCATION (City, town or county) (State) Baltimore Maryland
24. FUNERAL DIRECTOR Raymond L. Kaczorowski		25a. REC'D BY REGISTRAR MAY 15 1967	
ADDRESS 2525 Fleet St. 21224		25b. REGISTRAR'S SIGNATURE Charles Judge	

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C. 253

02184

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06267

CERTIFICATE OF DEATH

06257

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingsville 21087		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS Bellvue Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle G. Last FITZPATRICK				4. DATE OF DEATH Month May Day 16 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 17, 1899		9. AGE (In years lost birthday) 68 yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Field				14. MOTHER'S MAIDEN NAME Margaret Parrish			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-38-7693		17. INFORMANT Address Margaret F. Langrehr Bellvue Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO (b) Myocardial infarction with aneurysmal dilation of the heart DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour _____ a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that NO (this hospital) attended the deceased from May 10, 19 67 , to May 16, 19 67 , that NO (we) last saw the deceased alive on May 16, 19 67 , and that death occurred at 9:30 P.M. from causes and on the date stated above.							
22a. SIGNATURE Juana S. Cockburn M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED May 17, 1967	
22c. PHYSICIAN'S NAME (Type) Juana S. Cockburn, M.D.				22d. ADDRESS 7620 York Rd., Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 19, 1967		23c. NAME OF CEMETERY OR CREMATORY St. Francis Cemetery		23d. LOCATION (City or Town) (County) (State) Abingdon, Maryland	
24. FUNERAL DIRECTOR ADDRESS The Dippel Bro's Inc. 7110 Belair Rd.				25a. REC'D BY REGISTRAR MAY 19 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

08224

08224

10

February 11, 1950

Dear Sir:

Enclosed

Enclosed

Very truly yours,

Respectfully,
J. Edgar Hoover

Enclosure

Very truly yours,

W. A. Rorer, Jr.

W. A. Rorer, Jr., 1001 15th St., N.W., Washington, D.C.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

FOR STATE
HEALTH DEPT.

06263

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06258

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. LENGTH OF STAY IN 1b 15 min.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 43 W. Hicham Road				d. STREET ADDRESS 108 Hays Street			
3. NAME OF DECEASED (Type or print) First JAMES Middle D. Last FLANAGAN				4. DATE OF DEATH Month May Day 21 , 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-25-43	9. AGE (In years last birthday) 23 yrs.	IF UNDER 1 YEAR Months 23 Days 23 Hours 23 Min.	IF UNDER 24 HRS. Hours 23 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Loan Co.		11. BIRTHPLACE (State or foreign country) Austinville, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Steve Flanagan				14. MOTHER'S MAIDEN NAME Bertha M. Shupe			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 229-54-7997		17. INFORMANT Steve Flanagan, Austinville, Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Contact gunshot wound of head DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 976X DUE TO (c) Shot self in head							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in head					
20c. TIME OF INJURY Month, Day, Year 3:00 hour a.m. 5-21 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Baltimore Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Sprongate		EXAMINER'S NAME (Type) Charles S. Sprongate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED May 21, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF May 23, 1967		23c. NAME OF CEMETERY OR CREMATORY Vaughan, Gwynn, McGrade F.H.		23d. LOCATION (City or Town) (County) (State) Hillsville Carroll Va	
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md. 21009				25a. MAY 24 1967 DATE		25b. REGISTRAR'S SIGNATURE Charles Judge	

03238

03238

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.
OFFICE OF THE SECRETARY
ATTENTION: ASSISTANT SECRETARY FOR
GENERAL AFFAIRS
MAIL ROOM
MAIL STOP 100
WASHINGTON, D.C. 20250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06269

CERTIFICATE OF DEATH

06259

1. PLACE OF DEATH a. COUNTY Balto. CHAPPELL HILL NURSING HOME MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md., 21213 b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY IN 1b —	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CHAPELL HILL NURSING HOME		d. STREET ADDRESS 3444 Belair Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARIE A. FORD		4. DATE OF DEATH 9 ²⁵ 5 24 1967	
5. SEX F.		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 12/4/04	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY National Stationery	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? —	
13. FATHER'S NAME Oliver Ford		14. MOTHER'S MAIDEN NAME Fannie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT William Ford, Brother, above		Address —	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.A. of Pancreas & generalized DUE TO Metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — (c) —		INTERVAL BETWEEN ONSET AND DEATH —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-1-1967 to 5-24-1967, that (I) (we) last saw the deceased alive on 5/24 1967, and that death occurred at 9:30 M, from causes and on the date stated above.			
22a. SIGNATURE Cesar Valle Cervero		22b. DATE SIGNED 5/24/67	
22c. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERO		22d. ADDRESS 8629 Liberty Rd	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/27/67	
23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane		25a. REC'D BY REGISTRAR DATE MAY 26 1967	
25b. REGISTRAR'S SIGNATURE Judge			

02529

STATE OF NEW YORK

02529

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January 1, 1904

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06270

CERTIFICATE OF DEATH

06260

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lovson		c. LENGTH OF STAY IN 1b Essex 21221	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 701 Norris Lane	
3. NAME OF DECEASED (Type or print) Romana (Mina) First L. Middle Friedel Last		4. DATE OF DEATH May 17 1967 Month May Day 17 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-9-05
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Conrad Goub		14. MOTHER'S MAIDEN NAME Matilda ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216 56 7299	
17. INFORMANT Charles Friedel		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis left coronary artery 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction - 1 week duration DUE TO (c) Arteriosclerotic heart disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from May 17 1967 , to May 17 1967 , that (2) (we) last saw the deceased alive on May 17 1967 , and that death occurred at 6:45 PM from causes and on the date stated above.			
22a. SIGNATURE Juana S. Cockburn		22b. DATE SIGNED 5-18-67	
22c. PHYSICIAN'S NAME (Type) Juana S. Cockburn, M.D.		22d. ADDRESS 7620 York Rd. Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/22/67	23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus	23d. LOCATION (City or Town) (County) (State) Baltimore Co., Md.
24. FUNERAL DIRECTOR Bruzdinski		25a. REGISTRY MAY 22 1967	
24. ADDRESS Bruzdinski Funeral Home 1407 Eastern Ave.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06271

06261

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 21204				c. LENGTH OF STAY IN 1b 1 week			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dulaney Towson Nursing Home				d. STREET ADDRESS 940 OLMSTEAD ROAD			
3. NAME OF DECEASED (Type or print) JOSEPH				4. DATE OF DEATH Month May Day 4 Year 1967			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY MFG. REPRESENTATIVE		11. BIRTHPLACE (County & State, or foreign country) Atlantic City, N.J.	
13. FATHER'S NAME Samuel Frohsin				14. MOTHER'S MAIDEN NAME Lowella Snellenberg			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Address Baltimore, 21204 Dulaney Towson Nursing Home, 111 West Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized melanoma with brain metastasis 1909 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) melanoma DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 6 mos 6 yrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from May 2 1967 , to May 4 1967 , that (I) (we) last saw the deceased alive on May 2 1967 , and that death occurred at 12 PM , from the causes and on the date stated above.							
22a. SIGNATURE Jonas H. Cohen				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/4/67	
22c. PHYSICIAN'S NAME (Type) JONAS H. COHEN				22d. ADDRESS 6707 Park Heights Ave, BALTO. Md #21215			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/7/67		23c. NAME OF CEMETERY OR CREMATORY WOODON PARK CREMATORY		23d. LOCATION (City, town or county) _____ (State) _____ FREDERICK AVENUE	
24. FUNERAL DIRECTOR Sol Levinson Bros. 77				25a. REC'D BY REGISTRAR DATE MAY 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

13330

CERTIFICATE OF DEATH

08335

DEPARTMENT OF HEALTH
STATE OF MINNESOTA

MINNESOTA

DEPARTMENT OF HEALTH

REGISTERED

MINNESOTA

REGISTERED

MAY 1 1967

FOR STATE HEALTH DEPT.

06272

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06262

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 1007 Regester Avenue	
3. NAME OF DECEASED (Type or print) First MAX Middle R. Last FULLERTON		4. DATE OF DEATH Month May Day 4 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-8-1905
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 6 Days 2 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bureau Chief		10b. KIND OF BUSINESS OR INDUSTRY News Papers Ret.	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George S. Fullerton		14. MOTHER'S MAIDEN NAME Annie Robe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 233-10-6544	
17. INFORMANT Mrs. Virginia R. Fullerton		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 834.4 IMMEDIATE CAUSE (a) Cerebrocranial injuries DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell while getting out of car at home	
20c. TIME OF INJURY Month, Day, Year 11:40 p.m. 5 - 3 1967	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) curb - at home	20f. (City or town) (County) (State) Baltimore Md
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D.		22. DATE SIGNED May 5, 1967	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		Address (Street, city, town, or county) Baltimore, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 5-8-1967	23c. NAME OF CEMETERY OR CREMATORY Greenmount	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co.		25a. REC'D BY REGISTRAR MAY 10 1967	
ADDRESS 21212 4905 York Rd. Balto., Md.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08385

08385

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08-1-08

Amie Rose

George A. Ellington

37-10-34 Mr. Virginia A. Ellington

No

Amie Rose

George A. Ellington

37-10-34 Mr. Virginia A. Ellington

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06273

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06263

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 821		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1544 Rolling Rd. 21227			d. STREET ADDRESS 1544 South Rolling Road		
3. NAME OF DECEASED (Type or print) Harry Gorsuch Gallagher, Sr.			4. DATE OF DEATH Month May Day 26 Year 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/21/87 82		9. AGE (In years last birthday) 85 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Charles M. Gallagher		
14. MOTHER'S MAIDEN NAME Anna Handly			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT Harry G. Gallagher, Jr. Wife Pearl Gallagher 973 River Blvd., Suffield, Conn.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Carcinoma - Colon 1538 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO DUE TO DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ASCVD					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
22. DATE SIGNED 5/26/67		23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
24. ACTUAL SIGNATURE James N. Frederick, M.D. EXAMINER'S NAME (Type)		25. ADDRESS Howard H. Hubbard 4107 Wilkens Ave. 21229			
26a. BURIAL, CREMATION, REMOVAL (Specify) Burial		26b. DATE THEREOF 5/29/67		26c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
26d. LOCATION (City or Town) Baltimore, Md.		(County)		(State)	
27. REC'D BY REGISTRAR MAY 29 1967		28. REGISTRAR'S SIGNATURE Charles Judge			

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CERTIFICATE OF DEATH

Reg. Dist. No. 06254

06274

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase		c. LENGTH OF STAY IN lb Eight Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box-409 B. Rt. 16		e. STREET ADDRESS Box-409 B. Rt. 16	
3. NAME OF DECEASED (Type or print) First Olive Middle Beatrice Last Garrett		4. DATE OF DEATH Month May Day 9 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 22, 1892
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 8 Days 1 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Penn.	
11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME J. Nelson Palmer		14. MOTHER'S MAIDEN NAME Mary O. Wilhelm	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-42-3807A	
17. INFORMANT Mr. Charles R. Garrett		Address 29 Carlenda Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1750 METASTATIC INTRABD. CARCINOMA ASCITES DUE TO (b) 1750 INOPERABLE CARCINOMA OVARY DUE TO (c) 1750 Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.		INTERVAL BETWEEN ONSET AND DEATH 8 HRS. 1 YR.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/20 , 19 66 , to 5/9 , 19 67 , that I last saw the deceased alive on 5/8 , 19 67 , and that death occurred at 4:55 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert Healy		ADDRESS (Street, city or town, state) 3350 Wilkins Avenue	
PHYSICIAN'S NAME (Type) Robert Healy		DATE SIGNED 5/10/67	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/10/67	22c. NAME OF CEMETERY OR CREMATORY New Freedom Cemetery	22d. LOCATION (City, town, or county) (State) New Freedom Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Henry Sander & Sons Inc. Baltimore Md.		24. RECEIVED BY REGISTRAR MAY 12 1967	
ADDRESS Henry Sander & Sons Inc. Baltimore Md.		24b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

06374

06374

STATEMENT OF CHARGE

First Year of School, 1911-1912

1911-1912

1911-1912

1911-1912

1911-1912

1911-1912

1911-1912

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06275

CERTIFICATE OF DEATH

06265

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Josephs Hospital		d. STREET ADDRESS Putty Hill Road	
3. NAME OF DECEASED (Type or print) First ROBERT Middle CORNELIUS Last GAY		4. DATE OF DEATH Month May Day 20 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 22 1905
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 03 Days 1 Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Technician		10b. KIND OF BUSINESS OR INDUSTRY T.V.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME William Henry Gay		14. MOTHER'S MAIDEN NAME Nellie Dutrow	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-09-8492	
17. INFORMANT Marie E. Gay, 5 Warren Lodge Ct. 21030		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pancreatitis. DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchiectasis, right lung.			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 20, 1967 , to May 20, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 20, 1967 , and that death occurred at 5:25 P.M. from causes and on the date stated above.			
22a. SIGNATURE Manuel S. Cockburn, M.D.		22b. DATE SIGNED 5/21/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 7620 York Road, Towson, Md. 21204	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF May 24, 1967	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION (City or Town) (County) (State) Parkville, Balto. Co., Md.
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204		25. REC'D BY REGISTRAR MAY 23 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

08372

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08372



7-14
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
06276 CERTIFICATE OF DEATH 06266

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN 1b MAYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>29 Normal Terrace</i>		d. STREET ADDRESS <i>29 Normal Terrace</i>	
3. NAME OF DECEASED (Type or print) First <i>Eva</i> Middle <i>Donovan</i> Last <i>German</i>		4. DATE OF DEATH Month <i>May</i> Day <i>5</i> Year <i>1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 11, 1895</i>
9. AGE (if years last birthday) <i>71</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Owen J. Donovan</i>		14. MOTHER'S MAIDEN NAME <i>Mary L. Miller</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Family records</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ANOXIA</i> DUE TO <i>BILATERAL PLEURAL EFFUSION</i> (b) <i>CARCINOMATOSIS (ADENOCARCINOMA OF BREAST)</i> DUE TO <i>CARCINOMATOSIS (ADENOCARCINOMA OF BREAST)</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>5 DAYS</i> <i>1 YEAR</i> <i>10 YEARS</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>AUG 28</i> , 19 <i>62</i> to <i>MAY 5</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>MAY 5</i> 1967, and that death occurred at <i>9:50</i> P.M., from the causes and on the date stated above.			
22a. SIGNATURE <i>Donald L. Somerville</i>		22b. DATE SIGNED <i>5/7/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>DONALD L. SOMERVILLE, MD</i>		22d. ADDRESS <i>25 W. PA. AVE. TOWSON, MD 21204</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 8, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Maria Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Towson, Maryland</i>	
24. FUNERAL DIRECTOR <i>John Burns' Sons, Towson, Maryland</i>		25a. REC'D BY REGISTRAR <i>MAY 10 1967</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

652

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06277

Item #8 Film #G389 6/5/67

CERTIFICATE OF DEATH

06267

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN 1b 30.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) College Manor Nursing Home		d. STREET ADDRESS 1918 East 31st. Street	
3. NAME OF DECEASED (Type or print) Anita First W. Middle Gibson Last		4. DATE OF DEATH Month 5 Day 26 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/23/82
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never worked		10b. KIND OF BUSINESS OR INDUSTRY Deal Island, Md.	
11. BIRTHPLACE (County & State, or foreign country) Deal Island, Md.		12. CITIZEN OF WHAT COUNTRY? —	
13. FATHER'S NAME Lazarus Wilson		14. MOTHER'S MAIDEN NAME Annie Price	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Laiverence Adams		6602 Elserod Ave. Baltimore, Md. 14	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute heart failure 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO (c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. —	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/5 , 19 65 , to 5/26 , 19 67 that (I) (we) last saw the deceased alive on 5/23 , 19 67 , and that death occurred at 10:30 M, from causes and on the date stated above.			
22a. SIGNATURE William F. Fritz		22b. DATE SIGNED 5/27/67	
22c. PHYSICIAN'S NAME (Type) WILLIAM F. FRITZ, M.D.		22d. ADDRESS 2 WEST UNIVERSITY PKWAY, 21218	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/29/1967	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Wm. F. Tinkner, 1800 North Ave. Balt., Md.		25a. REC'D BY REGISTRAR MAY 31 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge

62881

62881

Baltimore

Gibson

Anta

Handwritten signature or initials, possibly "Gibson".

Handwritten signature or initials, possibly "Anta".

Vertical text on the right margin, possibly a date or reference number.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
06278 CERTIFICATE OF DEATH 06268

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE c. LENGTH OF STAY IN lb 18 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GREATER BALTO. MED. CENTER				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lansdowne d. STREET ADDRESS 413 4th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) SAMUEL CARL GILES			4. DATE OF DEATH 5 1 1967				
5. SEX MALE		6. COLOR OR RACE CAU.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 9/17/190		9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Builder		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel		11. BIRTHPLACE (County & State, or foreign country) Beth., Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME GEORGE GILES				
14. MOTHER'S MAIDEN NAME SHOCKER			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service) --				
16. SOCIAL SECURITY NO. 213-69-2304A			17. INFORMANT PR. HISTORY Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory failure 163X DUE TO (b) massive pulmonary hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Carcinoma of lung PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from April 14, 1967 to May 1, 1967 that (I) (we) last saw the deceased alive on May 1, 1967 and that death occurred at 2:45 AM , from the causes and on the date stated above.					
22a. SIGNATURE Robert W. Smith		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5-1-67			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/3/67		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.			
23d. LOCATION (City, town or county) (State) Dorsey, Md.		24. FUNERAL DIRECTOR ADDRESS JOHN F. DENNY, Inc. 715 Light St.					
25a. REC'D BY REGISTRAR MAY 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge					

X 2-1-01

Robert M. Smith

May 1 01

April 14 3/4

May 1 01

Received of Mr. Robert M. Smith

May 1 1901

Cardio-respiratory failure
massive pulmonary embolism
cerebral anoxia of lung

dis-organism at history

SHOCKER

Brain, lungs

USA

GRACE EYES

of BODIES

North Street

WALL CAR.

X

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CASES

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GEORGE BATH AND CENTER

BALTIMORE

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MARRIAGE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06273

CERTIFICATE OF DEATH

06269

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital, Baltimore Md. 21204		d. STREET ADDRESS 8210 Pleasant Plains Rd. 21204	
3. NAME OF DECEASED (Type or print) First CHARLES Middle L Last GLODEK		4. DATE OF DEATH Month MAY Day 14 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-24-18
9. AGE (In years lost birthday) 48 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steelworker		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.	11. BIRTHPLACE (County & State, or foreign country) Baltimore
13. FATHER'S NAME Valentine Glodek		14. MOTHER'S MAIDEN NAME Marcella Jakoubowski	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-10-2587	17. INFORMANT Wife - Lillian - same
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Chronic renal failure DUE TO (c) Chronic renal failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5-4- , 1967 , to 5-14 , 1967 , that (I) (we) last saw the deceased alive on 5-14- , 1967 , and that death occurred on 5-14 , 1967 , from causes and on the date stated above.			
22a. SIGNATURE <i>Efraim L. Reyes</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 5-14-67
22c. PHYSICIAN'S NAME (Type) Efraim L. Reyes, M.D.		22d. ADDRESS 7620 York Road, Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-17-67	23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland.
24. FUNERAL DIRECTOR Johnson Funeral Home.		25a. REC'D BY REGISTRAR MAY 18 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06280

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06270

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 15, Md.		c. LENGTH OF STAY IN 1b 12 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Md. 21215		03-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4150 Fallstaff Rd., Baltimore, Md.		d. STREET ADDRESS 4150 Fallstaff Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Francesco First Middle Last		4. DATE OF DEATH May 12, Month Day Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 29, 1891
9. AGE (In years lost birthday) 75 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rosario Glorioso		14. MOTHER'S MAIDEN NAME Rosaria Saia	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-36-0069	
17. INFORMANT Mr. Joseph Glorioso, 117 Chestnut Hill Lane		Address Reisterstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery Disease DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201			INTERVAL BETWEEN ONSET AND DEATH 6 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a.m. none p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D.D. Caples M.D.		22. DATE SIGNED 5/15/67	
EXAMINER'S NAME (Type) D. D. CAPLES		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 16, 1967	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	23d. LOCATION (City or Town) (County) (State) Pikesville, Baltio., Md.
24. FUNERAL DIRECTOR Frank H. Newell, Pikesville, Md.		25. REC'D BY REGISTRAR MAY 17 1967	
25b. REGISTRAR'S SIGNATURE Charles J. [Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>													
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> c. LENGTH OF STAY IN 1b <u>5 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>—</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 301 d. STREET ADDRESS <u>320 S. Robinson ST.</u>							
3. NAME OF DECEASED (Type or print) <u>Helen E. Goepfert</u>						4. DATE OF DEATH Month <u>5</u> Day <u>7</u> Year <u>1967</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>CAU</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-27-08</u>		9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Unknown Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Luczkowski</u>						14. MOTHER'S MAIDEN NAME <u>Groslof</u> Groslop							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Patient's Chart</u> Address <u>—</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Atherosclerotic Cardiovascular disease</u> cause (a), stating the underlying cause last. (c) <u>with concomitant pernicious anemia</u>												INTERVAL BETWEEN ONSET AND DEATH <u>15 mins</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>5-7</u>, 19<u>67</u>, to <u>5-7</u>, 19<u>67</u>, that (I) (we) last saw the deceased alive on <u>5-7</u>, 19<u>67</u>, and that death occurred at <u>4:30</u> PM, from the causes and on the date stated above.													
22a. SIGNATURE <u>V.R. Batoyon, M.D.</u>												22b. DATE SIGNED <u>5-8-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>VIVIAN R. BATOYON</u>						22d. ADDRESS <u>—</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>5/11/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>				23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
24. FUNERAL DIRECTOR <u>M.F. SADOWSKI & SONS, 1808 EASTERN AVE</u>						25a. REC'D BY REGISTRAR <u>—</u>		25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>					
DATE <u>MAY 10 1967</u>													

SSS

with conventional techniques. This
 Atherosclerotic cardiovascular disease
 is a major cause of morbidity and mortality.

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06282

CERTIFICATE OF DEATH

06272

1. PLACE OF DEATH a. COUNTY <u>Baltimore County, Md.</u> <small>MARKED</small>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Baltimore, Md.</u>				c. LENGTH OF STAY in 1b <u>2 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General Hospital</u>				e. STREET ADDRESS <u>60 Southgate Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Jeanette</u> Middle <u>C.</u> Last <u>Goodman</u>				4. DATE OF DEATH Month <u>5</u> Day <u>12</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/6/87</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Broker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Isaacson Isaacson</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Forman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-34-2783</u>		17. INFORMANT Address <u>Miss Hilda Goodman Annapolis, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) - PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest failure 2°</u> DUE TO <u>4200</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ventricular tachycardia & Libullation</u> DUE TO <u>4 hrs.</u> (c) <u>Severe Arteriosclerosis Heart Failure</u> DUE TO <u>YEARS.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-11</u> , 19 <u>67</u> , to <u>5-13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-13</u> , 19 <u>67</u> , and that death occurred at <u>7:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Angela A. Toppan</u>				22b. DATE SIGNED <u>5-13-67</u>		22c. PHYSICIAN'S NAME (Type) <u>ANGELA A. TOPPAN</u>	
22d. ADDRESS <u>BETH</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 15, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Kneseth Israel</u>		23d. LOCATION (City or Town) (County) (State) <u>Annapolis, Md. A.A., Md.</u>	
24. FUNERAL DIRECTOR <u>Beverley E. Hopping, Hopping Funeral Home</u>				25a. REC'D BY REGISTRAR <u>MAY 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
				25c. ADDRESS <u>Annapolis, Md.</u>			

05230

STATE OF NEW YORK

05230

To the Honorable

Assembly

and

Senate

of the State of New York

Resolved

That

the sum of

one

hundred

thousand

dollars

and no part thereof

be and the same be

applied to the purchase of

land

for the use of the State

of New York

to be known as

the "Land Purchase Act of 1905"

and the same be and the same be

enacted into law

with the following

amendments

to the

constitution

of the State

of New York

as follows:



1905

APR 10

1905

NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06283

CERTIFICATE OF DEATH

06273

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 77 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7		d. STREET ADDRESS 7117 Chamberlain Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RALPH Middle MICHAEL Last GOONER		4. DATE OF DEATH May 13 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/15/25
9. AGE (In years last birthday) yrs. 42		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Fleet Truck Motors	
11. BIRTHPLACE (County & State, or foreign country) Milford, Dela.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Willis Gooner		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW1		16. SOCIAL SECURITY NO. 221 12 47 78	
17. INFORMANT Mrs. Ralph M. Gooner-7117 Chamberlain Rd.		18. ADDRESS Clinical Rcds, VA Hospital, Fort Howard, Md.	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) MULTIPLE ABSCESSSES, CHRONIC, LEFT PLEURAL CAVITY, LEFT LOWER THORACIC WALL, PELVIC CA VITY (c) METASTATIC ADENOCARCINOMA, LIVER AND MESENTERIC LYMPH NODES		INTERVAL BETWEEN ONSET AND DEATH Weeks Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Entero-Cutaneous Fistula		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (A) (this hospital) attended the deceased from Feb. 25 , 19 67 , to May 13 , 19 67 that (X) (we) last saw the deceased alive on May 13 , 19 67 , and that death occurred at 6 A. M, from causes and on the date stated above.			
22a. SIGNATURE Alfonso A. Lopez, M.D.		22b. DATE SIGNED 5/13/67	
22c. PHYSICIAN'S NAME (Type) ALFONSO A. LOPEZ, M.D.		22d. ADDRESS VA Hospital, Fort Howard, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/16/67	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR WITZKE FUNERAL HOME		25a. REC'D BY REGISTRAR DATE MAY 16 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

12520

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10

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06284

CERTIFICATE OF DEATH

06274

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b TOWSON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 58 St. Josephs Hospital		d. STREET ADDRESS 2501 Hillford Drive	
3. NAME OF DECEASED (Type or print) First Edwin Middle Rayne Last GOWLAND		4. DATE OF DEATH Month May Day 25 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1894
9. AGE (In years lost birthday) yrs. 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine	
10b. KIND OF BUSINESS OR INDUSTRY Crown C+S		11. BIRTHPLACE (County & State, or foreign country) Penn	
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME Mr. Frederick Gowland	
14. MOTHER'S MAIDEN NAME M. A. Feistil		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give what or dates of service) yes	
16. SOCIAL SECURITY NO. 188-05-6564		17. INFORMANT Family Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema secondary to anemic 2924 DUE TO Heart Disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to hypoplasia of bone marrow. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 22 , 1967, to May 25 , 1967, that (I) (we) last saw the deceased alive on May 25 , 1967, and that death occurred at 1:30 M. from causes and on the date stated above.			
22a. SIGNATURE Lawrence F. Misanik, M.D.		22b. DATE SIGNED am	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 7620 York Rd. Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 5-26-1967	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cem		23d. LOCATION (City or town) (County) (State) York Penn	
24. FUNERAL DIRECTOR C. F. Evans & Son		25a. REC'D BY REGISTRAR 8802 Harford Rd	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAY 29 1967	

13520

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06285

CERTIFICATE OF DEATH

06275

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 19 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 30-4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 4409 Fernhill Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First VICTOR Middle VINCENT Last GRELLI				4. DATE OF DEATH Month MAY Day 27 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 11/11/18		9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY U.S. Coast Guard		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Vincent Grelli				14. MOTHER'S MAIDEN NAME Philomenia			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 213-14-82-04		17. INFORMANT Address Clin. Rec. VA HOSPITAL, Ft. Howard, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRAIN TUMOR LEFT FRONTAL LOBE 237X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from May 8 , 19 67 , to May 27 , 19 67 , that (we) last saw the deceased alive on May 27 , 19 67 , and that death occurred at 7:00AM from causes and on the date stated above.							
22a. SIGNATURE ZUI-SUN TAO				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/27/67	
22c. PHYSICIAN'S NAME (Type) ZUI-SUN TAO, M.D.				22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-31-67		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
25a. REC'D BY REGISTRAR Charles Judge				25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE MAY 31 1967	
25d. ADDRESS 4600 Liberty Hgts Ave Baltimore, Maryland							

27

MEDICAL CERTIFICATION

1

100

Funeral Director
Armacost Funeral Home

CERTIFICATE OF DEATH

08282

08282

Blank certificate form with faint lines and text.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06286

CERTIFICATE OF DEATH

06276

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) THOMAS CLIFTON GRIMES		4. DATE OF DEATH Month 5 Day 10 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/20/1892
9. AGE (In years last birthday) 74 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM GRIMES		14. MOTHER'S MAIDEN NAME DELLA EYLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-10-0479	
17. INFORMANT Records, Mount Wilson State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 Congestive heart failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Chronic obstructive airway disease (Emphysema)		INTERVAL BETWEEN ONSET AND DEATH 7 days 15 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5.6 , 19 67 , to 5.10 , 19 67 , that (I) (we) last saw the deceased alive on 5.10 , 19 67 , and that death occurred at 5:40 AM , from causes and on the date stated above.			
22a. SIGNATURE Wm. Newcomer		22b. DATE SIGNED 5.10.1967	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-13-67	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	23d. LOCATION (City or Town) (County) (State) Frederick, Fred. Md.
24. FUNERAL DIRECTOR Francis H. Barber		25. REG'D BY REGISTRAR MAY 12 1967	
ADDRESS Laytonsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

02581

Francis S. Hart
Hartsville, Md.

06287

CERTIFICATE OF DEATH

06277

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland #21231 b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St Joseph Hospital		d. STREET ADDRESS 1807 Aliceanna St.	
3. NAME OF DECEASED (Type or print) First Constance Middle A. Last Gruszczynski		4. DATE OF DEATH Month 5 Day 16 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/23/1897
9. AGE (In years by birthday) yrs. 70		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Lawrence Milanicz		14. MOTHER'S MAIDEN NAME Agnes Gliniski	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-01-0821	
17. INFORMANT Gilbert Gruszczynski - 1807 Aliceanna St.		Address #21231	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bedridden, Perpheric Edema DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Radical Rt. Mastectomy for Ca. of the Breast		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/26 , 1967 to 5/16 , 1967 , that (I) (we) last saw the deceased alive on 5/16 , 1967 , and that death occurred at 6:15 p.m. from causes and on the date stated above.			
22a. SIGNATURE Roberto O. Ferrer		22b. DATE SIGNED 5-16-67	
22c. PHYSICIAN'S NAME (Type) Roberto O. Ferrer		22d. ADDRESS 7620 York Rd. Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/20/67	
23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR George A. Weber 705 S. Ann Street		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAY 18 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

068271

068271

100-111001

RECEIVED

100-111001

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06288

06278

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			c. LENGTH OF STAY IN 1b <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Maryland</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>				d. STREET ADDRESS <u>3626 Lochearn Dr</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Aloysius</u> Last <u>Gwyer</u>				4. DATE OF DEATH Month <u>5</u> Day <u>29</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>10/3/86</u>		9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Road Contractor</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pittsburgh, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John Gwyer</u>				14. MOTHER'S MAIDEN NAME <u>Mary Bohland</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-10-2601</u>		17. INFORMANT <u>PATIENT'S CHART</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO (c) <u>MYOCARDIAL INFARCTION</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BRONCHOPNEUMONIA</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/24</u> , 19 <u>67</u> , to <u>5/29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 29</u> 19 <u>67</u> , and that death occurred at <u>2:45</u> P.M., from causes and on the date stated above.							
22a. SIGNATURE <u>Evelyn L. Ramos M.D.</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>EVELYN L. RAMOS, M.D.</u>				22d. ADDRESS <u>G.B.M.C., Towson 4</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6/1/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Droid Ridge Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO. CO. MD</u>	
24. FUNERAL DIRECTOR <u>BURGER FUNERAL HOME 3634 FALLS RD</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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00333

00333

PULMONARY COMPT
CONGESTIVE HEART FAILURE

MYOCARDIAL INFARCTION

BRONCHOPNEUMONIA

May 27 1947
2/27 1947

X

EVANS & RAMOS M.D. C.B.M.G. Town &

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

06283

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06279

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 818 Fairway Drive				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson d. STREET ADDRESS 818 Fairway Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES MATHIAS HAHN				4. DATE OF DEATH Pronounced Month Day Year 5 3 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12, '35		9. AGE (In years lost birthday) yrs. 31	10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		11b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob H. Hahn				14. MOTHER'S MAIDEN NAME Hilda Beutgen			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Lillian J. Rosenberg Address Spring Lane 14 W. Cold			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in head					
20c. TIME OF INJURY Hour a.m. p.m. Unknown		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Towson Balto. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE RUSSELL S. FISHER, M.D.		EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED 5-3-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 6, 1967		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery Baltimore Maryland		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Baltimore St.				25a. REG'D BY REGISTRAR MAY 8 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

00332

00332



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06290

06280

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital - DOA				d. STREET ADDRESS 1644 Muscatine Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KENNETH		First FRANKLIN		Last HAHN		4. DATE OF DEATH Month 5 Day 28 Year 1967	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-30-40	
9. AGE (In years last birthday) yrs. 26		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trainee-Manager		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert H. Hahn				14. MOTHER'S MAIDEN NAME Mary Jane Stine			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213 36 8962		17. INFORMANT Muscatine Sarah L. Hahn 1644 Muscatine Rd. 21204			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 8234 IMMEDIATE CAUSE (a) Craniocerebral injuries DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of auto which ran off road at Long Green and Hannibal Roads					
20c. TIME OF INJURY Month, Day, Year Hour, a.m. p.m. App. 12:20 a.m. 5-28-67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road		20f. (City or town) (County) (State) Baltimore Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) 22. DATE SIGNED 5-28-67			
23a. BURIAL, CREMATION, REINTERMENT Burial		23b. DATE THEREOF 5-31-67		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Baltimore 6, Maryland.	
24. FUNERAL DIRECTOR Wm. E. Johnson, 8521 Loch Raven Bl. Balto. Md.				25a. REC'D BY REGISTRAR JUN 5 1967		25b. REGISTRAR'S SIGNATURE 	

00520

you're kidding

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06291

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06281

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY in 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 818 Fairway Drive			d. STREET ADDRESS 818 Fairway Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARY Middle LOUISE Last HAHN			4. DATE OF DEATH Pronounced 5 3 1967		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 26, 1935		9. AGE (In years last birthday) 32 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Leo A. Rosenberger			14. MOTHER'S MAIDEN NAME Lillian J. Jacobs		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Mrs. Lillian J. Rosenberger Address Spring Lane 14 W. Cold	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head 981X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Presumably shot by husband			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. Unknown		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Towson Balto. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE RUSSELL S. FISHER, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 5-3-67	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/6/67	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Baltimore St.		ADDRESS		25a. REG'D BY REGISTRAR MAY 8 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

18329

18331

18331

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06292

CERTIFICATE OF DEATH

06282

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Armacost Con Home Register Ave		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson d. STREET ADDRESS 912 Chestnut Hill Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret Edna Hartig First Middle Last		4. DATE OF DEATH May 16/67 Month Day Year	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5 1918
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (County & State, or foreign country) Md
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Frederick Wirth	
14. MOTHER'S MAIDEN NAME Julia Martino		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Karl W Hartig 912 Chestnut Hill Ave Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of breast DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 year 7 years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from February , 19 67 , to May , 19 67 , that (I) (we) last saw the deceased alive on May 16 , 19 67 , and that death occurred at 2:15 PM , from causes and on the date stated above.			
22a. SIGNATURE Loy M. Zimmerman M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5/17/67
22c. PHYSICIAN'S NAME (Type) Loy M. Zimmerman M.D.		22d. ADDRESS 3202 Harford Rd. Baltimore, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF May 18/67	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore
24. FUNERAL DIRECTOR Ullrich Funeral Homes 4210 Belair Road ADDRESS		25a. REC'D BY REGISTRAR MAY 19 1967 DATE	25b. REGISTRAR'S SIGNATURE Charles Judge

32330

10-10-10

32330

10-10-10

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06293

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06283

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 709 Kingston, Rd.				c. LENGTH OF STAY IN 1b 5 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore,				d. STREET ADDRESS 709 Kingston, Rd.			
3. NAME OF DECEASED (Type or print) William E. Haverstick				4. DATE OF DEATH Month May Day 21 Year 67			
5. SEX M	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1, 1887		9. AGE (In years birthday) yrs. 79	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker				10b. KIND OF BUSINESS OR INDUSTRY Baking		11. BIRTHPLACE (State or foreign country) Adams Co. Pa.	
13. FATHER'S NAME Addison Haverstick				14. MOTHER'S MAIDEN NAME Anna Rudisill			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 213-30-6650			
17. INFORMANT Josephine Haverstick				Address 709 Kingston Rd.			
18. CAUSE OF DEATH (Enter only one cause for item 18. (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4281 Death Pulmonary Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Degeneration (c) Coronary Atherosclerosis						INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles F. O'Donnell				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) 5/21/67			
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE THEREOF May 24, 67		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION (City or Town) (County) (State) Cockeysville, Md.	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Tawson, Towson, Md.				25a. REC'D BY REGISTRAR DATE MAY 26 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

88320

88320

THE END OF THE WORLD

1950

1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
06294													
1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1648 FOREST PARK AVENUE						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD. b. COUNTY BALTO. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE d. STREET ADDRESS 1648 FOREST PARK AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) ROSA E. HAYNIE						4. DATE OF DEATH Month 5 Day 19 Year 1967							
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH I/30/83		9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME CHARLES WALKER						14. MOTHER'S MAIDEN NAME UNKNOWN							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO.		17. INFORMANT FAMILY - SAME				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA - RECTUM 154X DUE TO Conditions, if any, which gave rise to immediate cause (b) 5 GENERALIZED CARCINOMATOSIS. (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 18 mo			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)													
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 6/1/5 , 19 66 , to 5/19 , 19 67 , that (I) (we) last saw the deceased alive on 5/18 , 19 67 , and that death occurred at 3 A.M. , from the causes and on the date stated above.													
22a. SIGNATURE Norman R. Kleiman M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) NORMAN R. KLEIMAN						22d. ADDRESS 3803 Edmondson Ave -							
22e. DATE SIGNED 5/20/67													
23a. BURIAL, CREMATION, REMOVAL (Specify) B				23b. DATE THEREOF 5/22/67		23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE				23d. LOCATION (City, town or county) (State) BALTIMORE MD			
24. FUNERAL DIRECTOR'S SIGNATURE W. G. Gully - 237 Tataposee Ave.						ADDRESS		25a. REC'D BY REGISTRAR MAY 22 1967				25b. REGISTRAR'S SIGNATURE J. Charles Judge	

MEDICAL CERTIFICATION

00330

00330

MAY 2 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06295

CERTIFICATE OF DEATH

06285

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RANDALLSTOWN		c. LENGTH OF STAY IN 1b 3 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO.		031	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BALTO. COUNTY GEN. HOSP.		d. STREET ADDRESS 6003 WINDSOR MILL RD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LULA Middle B. Last HEARN		4. DATE OF DEATH Month 5 Day 2 Year 19 67	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/30/84
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PATRICK ALBION		14. MOTHER'S MAIDEN NAME ROSA BYRD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT Edward D. Hearn 6003 Windsor Mill Rd.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) REFRACTORY CONGESTIVE HEART FAILURE 4221 DUE TO ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 10 1/2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/29/67 , 19__ to 5/2/67 , 19__, that (I) (we) last saw the deceased alive on 5/2/67 , 19__, and that death occurred at 0:15 PM , from causes and on the date stated above.			
22a. SIGNATURE Dr. Milton Schlenoff		22b. DATE SIGNED 5-2-67	
22c. PHYSICIAN'S NAME (Type) MILTON SCHLENOFF		22d. ADDRESS BALTO COUNTY HOSP	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/6/67	
23c. NAME OF CEMETERY OR CREMATORY Parsons		23d. LOCATION (City or Town) (County) (State) Salisbury Maryland	
24. FUNERAL DIRECTOR J. J. STANSBURY		25a. REC'D BY REGISTRAR MAY 4 1967	
ADDRESS 6411 Windsor Mill Rd.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

88329

RECEIVED IN CLEAR

88329



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MAY 1 1951

CERTIFICATE OF DEATH

Reg. Dist. No. 06286

06296

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 625 Myers Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle S. Last Herrick Herrick				4. DATE OF DEATH Month May Day 20 Year 19 67			
5. SEX Male		6. COLOR OR RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 29, 1887	
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY U.S. Civil Service			
11. BIRTHPLACE (State or foreign country) Balto., Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Late - William J. Herrick				14. MOTHER'S MAIDEN NAME Unk.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. 219-14-0967			
17. INFORMANT Mrs. Joseph Galkas Address 625 Myers Drive - 21228							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure 416 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Cardia-vascular disease DUE TO (c) Laryngectomy for Ca of Larynx							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Laryngectomy for Ca of Larynx							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I of Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.							
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from October , 19 66 , to May 20 , 19 67 , that I last saw the deceased alive on May 19 , 19 67 , and that death occurred at 7 A.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 303 N. Rolling Rd. DATE SIGNED 5/20/67							
ACTUAL SIGNATURE D. C. MacLaughlin M.D. 303 N. Rolling Rd.							
PHYSICIAN'S NAME (Type) D. C. MacLaughlin							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF 5/23/67							
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.							
22d. LOCATION (City, town, or county) (State) Baltimore, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Witzke F. D. - 4101 Edmondson Ave. ADDRESS							
24a. REC'D BY REGISTRAR MAY 22 1967 24b. REGISTRAR'S SIGNATURE Charles Judge							

21

02386

CERTIFICATE OF DEATH

02386

Baltimore

Catonville

625 Myers Drive

Mission

Wm. C.

Bethesda

John - William F. Hendrick

U.S.

you W I 219-11-0960

625 Myers Drive - 219-11-0960

Wm. C. - 219-11-0960

Wm. C. - 219-11-0960

Baltimore National Cem. Baltimore, Md.

300 S. Hollins Rd.

D.O. Maclean Rd.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06297

06287

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY in 1b 03-1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234 d. STREET ADDRESS 2032 E. Joppa R. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Louise Sproull HILL				4. DATE OF DEATH Month Day Year May 11, 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 23, 1888	
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William A. Sproull				14. MOTHER'S MAIDEN NAME Elizabeth Chipley			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 213-12-2606A		17. INFORMANT William S. Hill Address Above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 9/60 DUE TO Septicemia (b) Dehydration DUE TO 25% Body 3rd Burns Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1				INTERVAL BETWEEN ONSET AND DEATH 17 Days			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Nothing caught fire reaching over Electric Stove					
20c. TIME OF INJURY Month, Day, Year 2:30 p.m. 4/11/67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. City or town (County) (State) Carney Balto Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles F. O'Donnell M.D.				22. DATE SIGNED 5/11/67			
EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-13-67		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		23d. LOCATION (City or Town) (County) (State) Baltimore Co. Md.	
24. FUNERAL DIRECTOR H.W.Jenkins & Sons Co.				25a. REC'D BY REGISTRAR MAY 15 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	
ADDRESS 3905 York Rd., Balto							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

Autopsies performed by family members are not permitted.

Copy of this to pay to be sent to Chief Medical Examiner's Office.

1833

1833



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #6 Film #G380 6/6/67

06298

CERTIFICATE OF DEATH

06288

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 594A Yale Street			
3. NAME OF DECEASED (Type or print) ALBERT L HILLIARD				4. DATE OF DEATH Month May Day 30 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1889		9. AGE (In years last birthday) yrs. 78	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SOLDIER		10b. KIND OF BUSINESS OR INDUSTRY U. S. ARMY		11. BIRTHPLACE (County & State, or foreign country) Wilmerding, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unk				14. MOTHER'S MAIDEN NAME VICTORIA MN: OGROWSKI			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 218 26 33 06		17. INFORMANT Address Clinical Rcds, VA Hospital, Ft Howard Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA 1621 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CORONARY HEART DISEASE						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 24 , 19 67 , to May 30 , 19 67 , that <input checked="" type="checkbox"/> (we) lost the deceased alive on May 30 , 19 67 , and that death occurred at 10:30 AM from causes and on the date stated above.							
22a. SIGNATURE <i>Peter V. Juvan</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/31/67	
22c. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/2/67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR MC CULLY FUNERAL HOME				25a. REC'D BY REGISTRAR JUN 2 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

ADDRESS
MC CULLY FUNERAL HOME
PORT AVENUE, BALTIMORE, MD.

00238

00238

Baltimore

Baltimore

Baltimore

6 days

Fort Howard

2911 Yale Street

Veterans Administration Hospital

X

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May

REINHARD

1

ALBERT

78

May 22, 1989

X

Male

U.S.A.

Birmingham, Penna.

BIRMINGHAM, PENNA.

Yes 218 26 33 06 Clinical Beds, VA Hospital, Ft Howard Md.

BIRMINGHAM, PENNA.

BIRMINGHAM, PENNA.

X

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May 30

May 24

May 24

07

May 30

X

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06299

CERTIFICATE OF DEATH

06289

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN 1b 40 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 11001 Reisterstown Road			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills d. STREET ADDRESS 11001 Reisterstown Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First JOHN Middle BERNARD Last HOFF			4. DATE OF DEATH Month May Day 11 Year 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 18, 1887		9. AGE (In years last birthday) 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Driver		10b. KIND OF BUSINESS OR INDUSTRY Belto. Transit	11. BIRTHPLACE (County & State, or foreign country) Owings Mills, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME John Hoff			14. MOTHER'S MAIDEN NAME Mary Lee Cantwell		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-05-9144	17. INFORMANT Mrs. Kate E. Hoff, 11001 Reisterstown Rd. Owings Mills, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Cardiovascular arteriosclerotic disease DUE TO (c) Decompensated Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. 5 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: ✓					INTERVAL BETWEEN ONSET AND DEATH Sudden
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ✓		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. ✓		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ✓		20f. (City or town) Reisterstown, Md. (County) ✓ (State) ✓
21. I certify that (I) (this hospital) attended the deceased from 5-11-67 to 5-11-67 , that (I) (we) last saw the deceased alive on 5-11-67 , and that death occurred at 11:15 M, from the causes and on the date stated above.					
22a. SIGNATURE James G. Saffell			22b. DATE SIGNED 5-13-67		
22c. PHYSICIAN'S NAME (Type) James G. Saffell			22d. ADDRESS Reisterstown, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/13/67	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City, town or county) Pikesville, Md. (State) ✓
24. FUNERAL DIRECTOR'S SIGNATURE H. J. Eckhardt			25a. REC'D BY REGISTRAR MAY 15 1967 25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 shall be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05228

05228

1101 Highway 100 Road

1100 Highway 100 Road

May 15 1963

MAY 15 1963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN ID 38yr11mth8dys d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 120 North Wolfe Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Samuel Middle Hoffman Last Hoffman			4. DATE OF DEATH Month May Day 23 Year 19 67			5. SEX male			6. COLOR OR RACE white		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Nov. 1899			9. AGE (in years last birthday) 67 yrs.			IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY none			11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME Samuel Hoffman						14. MOTHER'S MAIDEN NAME Annie Formen					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. 219-54-3163-T			17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			21. I certify that 4 (this hospital) attended the deceased from June 15 , 19 68 to May 23 , 19 67 , that 4 (we) last saw the deceased alive on May 23 , 19 67 , and that death occurred at 7:25 AM , from the causes and on the date stated above.			22a. SIGNATURE Stella Wachslar		
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.			22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228			22b. DATE SIGNED 5-23-67			22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 5/26/1967			23c. NAME OF CEMETERY OR CREMATORY Mt. CARMEL			23d. LOCATION (City, town or county) (State) BALTO. MD.		
24. FUNERAL DIRECTOR Sylvan S. Lewis & Son, Inc			ADDRESS GARRISON MD.			25a. REC'D BY REGISTRAR MAY 29 1967			25b. REGISTRAR'S SIGNATURE J. Charles Jones		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06301					06291				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY		Baltimore			a. STATE		Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rodgers Forge			b. COUNTY		Baltimore		
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS				
37 Dunkirk Road					37 Dunkirk Road				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last CHARLOTTE T. HOGAN					Month Day Year May 27, 19 67				
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		November 8, 1880		86 yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				Home		Baltimore, Maryland		U.S.A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Charles Rebstock					Charlotte				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT			Address	
No			220-07-8044		Mrs. Marie H. LaFleur			Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cronary Heart Disease</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerosis of Aorta</u> DUE TO (c) <u>A white embolus</u>									INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>10 yrs</u> <u>16 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>52</u> , to <u>May</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 10</u> 19 <u>67</u> , and that death occurred at <u>5 P</u> M, from the causes and on the date stated above.									22b. DATE SIGNED
22a. SIGNATURE <u>Dr. E.P. Coffay, Jr.</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
Dr. E.P. Coffay, Jr.					3100 St. Paul St. Baltimore				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		
Burial			5-31-67		New Cathedral		Baltimore, Maryland		
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Mitchell-Wiedefeld Home, Inc. 6500 York Rd.					JUN 1 1967		<u>Charles Judge</u>		

10530

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
20 M 1/66

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06302

CERTIFICATE OF DEATH

06292

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 7 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Carrollton		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital				d. STREET ADDRESS 6109 85th Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Margaret Cora Holson				4. DATE OF DEATH Month Day Year MAY 24 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 17, 1910		9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Sales Clerk		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (County & State, or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Vernon Hayden				14. MOTHER'S MAIDEN NAME Mary King			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 577-01-5526		17. INFORMANT Address Barbara A. Petro 6109 85th Place Recorder x Spring Grove State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) ARTERIOSCLEROSIS GENERALIZED AND SEVERE							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 27, 1966 to MAY 24, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MAY 24 1967 , and that death occurred at 6:33P M, from causes and on the date stated above.							
22a. SIGNATURE Morris Meiller				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED May 24, 1967	
22c. PHYSICIAN'S NAME (Type) MORRIS MEILLER M.D.				22d. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 27, 1967		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges Co., Md.	
24. FUNERAL DIRECTOR Thomas Schuchman Warner E. Pumphrey, Inc.				ADDRESS 8434 Georgia Avenue Silver Spring, Md.		25a. REC'D BY REGISTRAR MAY 26 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

5082C

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06303

CERTIFICATE OF DEATH

06293

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY —		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN IB 49 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL			d. STREET ADDRESS 4302 KOLB AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HENRY Middle ALLARD Last HOLT			4. DATE OF DEATH Month MAY Day 10 Year 19 67		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1/11/09		9. AGE (In years last birthday) 58 yrs.
10a. USUAL OCCUPATION* (Give kind of work done during most of working life, even if retired) CHAUFFEUR & SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) LOUISVILLE, KENTUCKY	
13. FATHER'S NAME WILLIAM HOLT			14. MOTHER'S MAIDEN NAME DAISY HOPKINS		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 215 03 10 95		17. INFORMANT CLINICAL RECORDS VAH FORT HOWARD, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRRHOSIS OF THE LIVER 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 22 , 19 67 , to MAY 10 , 19 67 that (I) (we) last saw the deceased alive on MAY 10 , 19 67 , and that death occurred at 7:30 AM , from causes and on the date stated above.					
22a. SIGNATURE <i>John D. Talbert</i>			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5-10-67
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.			22d. ADDRESS VA HOSPITAL FORT HOWARD, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5/12/67	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR ROBERT C. ALTENBURG		ADDRESS 6009 HARFORD RD. BALTIMORE, MARYLAND		25a. REC'D BY REGISTRAR MAY 15 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

00303

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DATE		TIME		PLACE	
1944		10:00		New York	
TO		FROM		SUBJECT	
Mr. [Name]		Mr. [Name]		[Subject]	
[Address]		[Address]		[Address]	
[City]		[City]		[City]	
[State]		[State]		[State]	
[Zip]		[Zip]		[Zip]	
[Phone]		[Phone]		[Phone]	
[Fax]		[Fax]		[Fax]	
[Email]		[Email]		[Email]	
[Website]		[Website]		[Website]	
[Social Media]		[Social Media]		[Social Media]	
[Other]		[Other]		[Other]	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06304

CERTIFICATE OF DEATH

06294

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center			d. STREET ADDRESS 3725 Fairhaven Avenue		
3. NAME OF DECEASED (Type or print) First Middle Last JAMES FRANCIS HOLY			4. DATE OF DEATH Month Day Year 5 15 19 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/5/01	9. AGE (In years lost birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Michael Holy			14. MOTHER'S MAIDEN NAME Nocar Marie		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-44-6632		17. INFORMANT Family Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple pulmonary emboli DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive and arteriosclerotic cardiovascular disease DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 5 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/8, 1967 , to 5/15, 1967 , that (I) (we) last saw the deceased alive on 5/15 19 67 , and that death occurred at 6 P.M. from causes on and on the date stated above.					
22a. SIGNATURE John E. Adams		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED MAY 16/1967	
22c. PHYSICIAN'S NAME (Type) JOHN E. ADAMS		22d. ADDRESS 6701 North Charles Street Balto. 21204			
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE THEREOF 5/19/67		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem	
				23d. LOCATION (City or Town) (County) (State) A A Co Md	
24. FUNERAL DIRECTOR McCully F H 237 Patapsco Ave 21225				25a. REC'D BY REGISTRAR MAY 19 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4032

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06305 RANDALLSTOWN CERTIFICATE OF DEATH

06295

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE County</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown, Md.</u>		c. LENGTH OF STAY IN 1b <u>70 min.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTIMORE GENERAL COUNTY Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Paul</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 6, 1930</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Exec. Designer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hungry</u>	
13. FATHER'S NAME <u>Andrew</u>		14. MOTHER'S M maiden name <u>Blanche</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-46-4082</u>	
17. INFORMANT <u>Veronica Homoki</u>		Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute MYOCARDIAL Infarct</u> DUE TO <u>3 CARDIAC ARREST</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HAS CVD</u> (c) <u>HAS CVD</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5-8-</u> , 19 <u>67</u> , to <u>5-8-</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-8-</u> , 19 <u>67</u> , and that death occurred at <u>4:45</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>Cesar Valle Caverro</u>		22b. DATE SIGNED <u>5-8-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>CESAR VALLE CAVERO</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	23b. DATE THEREOF <u>May 8, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Clara Adams Chapel</u>	23d. LOCATION (City or Town) (County) (State) <u>Randallstown Md</u>
24. FUNERAL DIRECTOR <u>Sybran S. Lewis & Son, Inc. Garrison, Md</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 10 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECEIVED OF STATE

00330

1947

NOV 14 1947
U.S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C.

06306

CERTIFICATE OF DEATH

06296

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb (2yrs 11 mo. 14 days)	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne, Maryland		21227	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) House in the Pines- Catonsville		d. STREET ADDRESS 242 Clyde Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Camilla E. Hopkins		4. DATE OF DEATH Month May Day 27 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 14, 1877
9. AGE (In years lost birthday) 89 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (County & State, or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Augustus Selby		14. MOTHER'S MAIDEN NAME Mary Ridgely	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Frank J. Willey Jr.		Address Md. 21228 109 Rosewood Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic C V D, Marked, generalized DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia, left lower lung			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/13/64 , 19__, to 5/27/67 , 19__, that (I) (we) last saw the deceased alive on 5/11/67 , 19__, and that death occurred at 2:10 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>Herbert J. Levickas</i>		22b. DATE SIGNED 5/29/67	
22c. PHYSICIAN'S NAME (Type) Herbert J. Levickas		22d. ADDRESS 1073 Maiden Choice Lane Balto. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 29, 1967	23c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery	23d. LOCATION (City or Town) (County) (State) Howard County, Maryland
24. FUNERAL DIRECTOR Easton Funeral Home		25a. REC'D BY REGISTRAR DATE MAY 31 1967	
ADDRESS Catonsville, Md.		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

42920

3063P



Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2

06297

1. PLACE OF DEATH a. COUNTY Baltimore County		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c. LENGTH OF STAY IN lb 11 wks 4 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle PINDELL Last HOWARD		4. DATE OF DEATH Month 5 Day 14 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/27/84
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER - LABORER		10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE	9. AGE (In years last birthday) 82 yrs.
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRANK HOWARD		14. MOTHER'S MAIDEN NAME EMMA HEDER KK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) UNKNOWN NONE		16. SOCIAL SECURITY NO. 216-05-2101	
17. INFORMANT Records, Mount Wilson State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CEREBRAL INFARCTION DUE TO (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE YEARS INTERVAL BETWEEN ONSET AND DEATH ACUTE MONTHS		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ABDOMINAL AORTIC ANEURYSM	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/24 , 19 67 , to 5/14 , 19 67 , that (I) (we) last saw the deceased alive on 5/13 , 19 67 , and that death occurred at 0820M , from causes and on the date stated above			
22a. SIGNATURE Wm. Newcomer		22b. DATE SIGNED 5/14/67	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MAY 17, 1967	23c. NAME OF CEMETERY OR CREMATORY Jessops Cemetery	23d. LOCATION (City or Town) (County) (State) Cockersville, Md.
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Md.		25a. REC'D BY REGISTRAR MAY 18 1967	
25b. REGISTRAR'S SIGNATURE James Judge			

10-10-68

60830

5224

R. 7-7667

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
06308		Items #6 & 9 Film #309 6/27/67				06298					
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>103 PARK DRIVE</u>						d. STREET ADDRESS <u>103 PARK DRIVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JAMES G. HOWELL</u>			First Middle Last			4. DATE OF DEATH Month <u>5</u> Day <u>24</u> Year <u>1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>CAU</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 7 1899</u>		9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOCTOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MEDICINE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>AITONA PENN.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>GEORGE A.</u>						14. MOTHER'S MAIDEN NAME <u>MARGARET CONDRIEN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. HOWELL</u>			Address <u>103 PARK DRIVE</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA</u> <u>1671</u> DUE TO (b) <u>BRONCHOGENIC CARCINOMA</u> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>										INTERVAL BETWEEN ONSET AND DEATH <u>6 MOS.</u> <u>6 MOS.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>DEC 6</u> , 19 <u>66</u> , to <u>MAY 24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>MAY 24</u> , 19 <u>67</u> , and that death occurred at <u>7:40 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>John H. Tuohy</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/24/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOHN H. TUOHY, M.D.</u>						22d. ADDRESS <u>ST. AGNES HOSP, BALTO 21294D.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5/27/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OLD TRINITY</u>		23d. LOCATION (City, town or county) (State) <u>CHURCH CREEK MD.</u>					
24. FUNERAL DIRECTOR <u>FARLEY-CAVANAUGH</u>						25a. REC'D BY REGISTRAR <u>MAY 29 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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SHIPPED TO: C. E. EDWARDS FUNERAL HOME, BOWLING GREEN, VIRGINIA

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06303

06299

1. PLACE OF BIRTH a. COUNTY		BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 113 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		304	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 1225 W. BALTIMORE STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First JAMES		Middle LLOYD		Last HUDSON	
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH MAY 24 1967	
9. AGE (In years last birthday) 57 yrs.		10. BIRTHPLACE (County & State, or foreign country) CAROLINE COUNTY, VIRGINIA		11. IF UNDER 1 YEAR Months Days		12. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (County & State, or foreign country) CAROLINE COUNTY, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EUGENE HUDSON		14. MOTHER'S MAIDEN NAME MAUDE ESLECK		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 218 07 56 57	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		18. ADDRESS CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC PULMONARY EMPHYSEMA WITH RESPIRATORY FAILURE DUE TO (b) PULMONARY TUBERCULOSIS, FAR ADVANCED, INACTIVE DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) COR PULMONALE		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 1/31/67, 19 to 5/24/67, 19, that (X) (we) last saw the deceased alive on 5/24/67, 19, and that death occurred at 8:00P M, from causes and on the date stated above.		22a. SIGNATURE Peter V. Juvan		22b. DATE SIGNED 5/25/67			
22c. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 5-28-67		23c. NAME OF CEMETERY OR CREMATORY SPARTA CEMETERY		23d. LOCATION (City or Town) (County) (State) SPARTA, VIRGINIA	
24. FUNERAL DIRECTOR ELROY O WILSON FUNERAL HOME ORLEANS ST. BALTIMORE, MD.		25a. REC'D BY REGISTRAR MAY 26 1967		25b. REGISTRAR'S SIGNATURE Charles J. Juvan			

VR A15 (4)
25M 1/67

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06310

CERTIFICATE OF DEATH

06300

1. PLACE OF DEATH a. COUNTY Baltimore County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c. LENGTH OF STAY IN 1b 2 1/2 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishopville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital				d. STREET ADDRESS R7D.	
3. NAME OF DECEASED (Type or print) WALTER JAMES HUDSON				4. DATE OF DEATH Month 5 Day 10 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 11.22.1915		9. AGE (In years last birthday) yrs. 51
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME WALTER HUDSON			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 214-34-7239		
17. INFORMANT Address Records, Mount Wilson State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung with multiple metastasis DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 163X					INTERVAL BETWEEN ONSET AND DEATH 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0026 Pulmonary tuberculosis					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 2.21.1967 to 5.10.1967 that (I) (we) last saw the deceased alive on 5.10.1967 , and that death occurred at 9:20 AM , from causes and on the date stated above					
22a. SIGNATURE Wm. Newcomer			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5.10.1967
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent Mount Wilson, Maryland			22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/13/67	23c. NAME OF CEMETERY OR CREMATORY L.O.O.F.	23d. LOCATION (City or Town) (County) (State) Bishopville Worcester Md.		
24. FUNERAL DIRECTOR Wm. H. Hales Salisbury Del.			25a. REC'D BY REGISTRAR MAY 15 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06311

CERTIFICATE OF DEATH

06301

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7208 Linden Avenue</u>				d. STREET ADDRESS <u>7208 Linden Avenue</u>			
3. NAME OF DECEASED (Type or print) <u>SALLIE F. HYMAN</u>				4. DATE OF DEATH Month <u>5</u> Day <u>22</u> Year <u>19 67</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>N.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-25-1899</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WINDSOR, NORTH CAROLINA</u>	
13. FATHER'S NAME <u>Soloman</u>				14. MOTHER'S MAIDEN NAME <u>SALLIE SIMMONS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give year or dates of service)</u>				17. INFORMANT <u>Mrs. Mable Williams</u> Address <u>7208 Linden Avenue</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO (b) <u>Carcinoma of Cervix</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u></u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1967</u> to <u>May 21 1967</u> that (I) (we) last saw the deceased alive on <u>May 21 1967</u> and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.				22a. SIGNATURE <u>G. M. BAUMGARDNER</u> M.D.			
22c. PHYSICIAN'S NAME (Type) <u>G. M. BAUMGARDNER</u>				22d. ADDRESS <u>BALTO 2120 6</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-25-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>		23d. LOCATION (City, town or county) (State) <u>BALTO</u> <u>MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>MORRIS DYETT F.H.</u>				25. REC'D BY REGISTRAR <u>Charles Judge</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				25c. DATE <u>MAY 24 1967</u>			

06311

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MARYLAND

Oxley

BALTIMORE

7308 Linden Avenue

7308 Linden Avenue

SALARY

HYMAN

67 52 5

M. E.

1-25-1997

BB

RETIRED

WINDSOR, NORTH CAROLINA

U.S.A.

SALARY SINKING

7308 Linden Avenue Mrs. Table Williams

Handwritten notes and signatures at the bottom of the page, including a date "May 11 1997" and a signature "J. E. Williams".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06312

CERTIFICATE OF DEATH

06302

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c. LENGTH OF STAY IN 1b 6 months.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FRANK GREEN JACOBS		4. DATE OF DEATH Month Day Year 5 / 4 / 19 67	
5. SEX M.	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/28/05
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Jacobs		14. MOTHER'S MAIDEN NAME Beverly Anthony	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 227-07-9331	
17. INFORMANT Records, Mount Wilson State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulm. TB, FA, occlusive. DUE TO (b) Rt. pleural effusion, TB. DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Alcoholism		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/5/66, to 5/4/1967 , that (I) (we) last saw the deceased alive on 5/4/1967 , and that death occurred 3:20 A.M. from causes and on the date stated above.			
22a. SIGNATURE W. Newcomer		22b. DATE SIGNED 5/4/67.	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) 5-7-67		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Peaverdam Ch Cemt		23d. LOCATION (City or Town) (County) (State) Goodview, Va	
24. FUNERAL DIRECTOR David Federal Home Services - 8-Mt		25a. REC'D BY REGISTRAR MAY 9 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

102308

CERTIFICATE OF DEATH

102318

Name of Deceased		Date of Birth	
Sex		Race	
Marital Status		Place of Birth	
Occupation		Education	
Cause of Death		Date of Death	
Place of Death		Signature of Physician	
Signature of Registrar		Signature of Informant	
Date of Registration		Place of Registration	



Vertical text on the right margin, possibly a filing number or date.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06313

CERTIFICATE OF DEATH

06303

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md., 21206 b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7911 Elmhurst Ave.		d. STREET ADDRESS 7911 Elmhurst Ave.	
3. NAME OF DECEASED (Type or print) First RICHARD Middle WILSON Last JACOBS		4. DATE OF DEATH Month May Day 21 Year 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12/25/12
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months 6 Days 1 Hours 1 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		11b. KIND OF BUSINESS OR INDUSTRY Fisher Body Co.	
12. BIRTHPLACE (County & State, or foreign country) Virginia		13. CITIZEN OF WHAT COUNTRY?	
14. FATHER'S NAME Richard J. Jacobs		15. MOTHER'S MAIDEN NAME Mary S. Propst	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		17. SOCIAL SECURITY NO. 217-03-4514	
18. INFORMANT Mary S. Propst, mother, above		Address	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 148X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA PHARYNX DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 6 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 5, 1966 , to May 21, 1967 , that (I) (we) last saw the deceased alive on May 19, 1967 , and that death occurred at 1:00 AM , from causes and on the date stated above.			
22a. SIGNATURE Dr. John B. Littleton		22b. DATE SIGNED May 22, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. John B. Littleton		22d. ADDRESS 1012 Old North Point Rd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 5/25/67	23c. NAME OF CEMETERY OR CREMATORY Sangersville Cemetery	23d. LOCATION (City or Town) (County) (State) Sangersville, Va.
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane		25a. REC'D BY REGISTRAR MAY 23 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>																	
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore												
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 22yr6mth15 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore												
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL					d. STREET ADDRESS 5220 Overcrest Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Loretta C.					4. DATE OF DEATH May 19 1967												
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 10, 1891		9. AGE (In years last birthday) 76 yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.																
Months	Days																
	Hours																
	Min.																
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.									
13. FATHER'S NAME John Bezold					14. MOTHER'S MAIDEN NAME Theresa Peters												
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <table border="1"> <tr> <td>(If yes give war or dates of service)</td> </tr> </table>				(If yes give war or dates of service)	16. SOCIAL SECURITY NO. 220-46-0264T		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL										
(If yes give war or dates of service)																	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured aortic aneurysm due to generalized A.S.C.V.D. 451X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of the Breast.																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from Sept. 16 , 19 44 , to May 19 , 19 67 , that (I) (we) last saw the deceased alive on May 19 , 19 67 , and that death occurred at 5:10 P.M. , from the causes and on the date stated above.																	
22a. SIGNATURE Vicente M. Ruano						22b. DATE SIGNED May 20, 1967											
22c. PHYSICIAN'S NAME (Type) Vicente M. Ruano						22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/23/67		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Md.											
24. FUNERAL DIRECTOR Wm. J. Tinkens				25a. REC'D BY REGISTRAR May 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06315

06305

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 3 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 1, Cockeysville, 21030		03-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS Box 355, Happy Hollow Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Lamont Last JAMES		4. DATE OF DEATH Month May Day 16 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1912
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Oxygen	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME David James		14. MOTHER'S MAIDEN NAME Annie Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WW II		16. SOCIAL SECURITY NO. 166-09-9411	
17. INFORMANT: wife Mary F. James, Cockeysville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage, left hemisphere 443X DUE TO (b) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arteriosclerotic cardiovascular disease DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from May 13 , 19 67 , to May 16 , 19 67 at (we) lost saw the deceased alive on May 16 , 19 67 , and that death occurred at 2:10pM , from causes on and on the date stated above.			
22a. SIGNATURE Manuel Cockburn, M.D.		22b. DATE SIGNED May 16, 1967	
22c. PHYSICIAN'S NAME (Type) Manuel Cockburn, M.D.		22d. ADDRESS 7620 York Road, Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/19/1967	
23c. NAME OF CEMETERY OR CREMATORY Springhill Cemetery		23d. LOCATION (City or Town) (County) (State) Easton, Maryland	
24. FUNERAL DIRECTOR Stewart & Mowen Co., 108 W. North Av., Balto.		25a. REC'D BY REGISTRAR DATE May 18 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

00302

INSTRUMENT OF DEED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06306

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 21222	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8 Centre Avenue		d. STREET ADDRESS 8 Centre Avenue	
3. NAME OF DECEASED (Type or print) First MAX Middle (NMN) Last JANOWICH		4. DATE OF DEATH Month May Day 18th Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 16, 1886
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landlord		10b. KIND OF BUSINESS OR INDUSTRY Property Mgt.	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME (unknown) Janowich		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-03-8374A	
17. INFORMANT Steve Janowich		Address Box 672-Route 15 Baltimore, Md. 21220	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Throat 148X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary + Hepatic DUE TO (c) metastatic		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/13 19 67 , to 5/18 19 67 , that I last saw the deceased alive on 5/17 19 67 , and that death occurred at M from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Theodore C. Patterson M.D.		105 Main Street 5/19/67	
PHYSICIAN'S NAME (Type) Theodore C. Patterson, M.D.		Baltimore, Maryland 21222	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/20/67	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc.		ADDRESS Dundalk 22	
24. REC'D BY REGISTRAR MAY 22 1967		24b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

06317

06307

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5500 -B- Race Road</u>				d. STREET ADDRESS <u>5500 -B- Race Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Ellen</u> Middle <u>Roberta</u> Last <u>Jarvis</u>				4. DATE OF DEATH Month <u>May</u> Day <u>4</u> Year <u>19 67</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October, 11, 1911</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Elkridge, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				13. FATHER'S NAME <u>James Taylor</u>			
14. MOTHER'S MAIDEN NAME <u>Nannie B. Robinson</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT <u>Mr. Allen Jarvis Jr 5500 -B- Race Road</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of liver</u> <u>581.0</u> DUE TO <u>Chronic Hemorrhages</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Cardio Vascular disease</u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Apr 1, 1967</u> , to <u>May 4, 1967</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>May 4, 1967</u> , and that death occurred at <u>8:03 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>B B Brumbaugh</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>B B Brumbaugh MD</u>				22d. ADDRESS <u>5609 Main St Elkridge Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/8/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Herbert E. Nutter</u>				ADDRESS <u>3035 W. North Ave Baltimore, Md</u>		25a. REC'D BY REGISTRAR <u>MAY 8 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06318

06308

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton				c. LENGTH OF STAY IN 1b yrs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 525 Old Home Road				d. STREET ADDRESS 525 Old Home Road 36			
3. NAME OF DECEASED (Type or print) First ROLAND Middle LEE Last JONES				4. DATE OF DEATH Month 5 Day 9 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-3-1905	9. AGE (In years lost birthday) yrs 62	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aircraft		10b. KIND OF BUSINESS OR INDUSTRY Boeing Aircraft		11. BIRTHPLACE (State or foreign country) Denton, Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME William Jones				14. MOTHER'S MAIDEN NAME Carrie Anthony			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-12-2416		17. INFORMANT Mrs Clara Figgs 1503 W. 36th Street		Address 21211	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of liver 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> Partial	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Partial		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.		EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 5-9-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-12-1967		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Co. Md.	
24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road				25a. REC'D BY REGISTRAR MAY 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

61837

[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)
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Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove both papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06313

CERTIFICATE OF DEATH

06309

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21207</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General Hospital</u>		d. STREET ADDRESS <u>4104 Buckingham Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>B.</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>5</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-8-24</u>
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Office</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ft. Holobird</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas B. Jones sr.</u>		14. MOTHER'S MAIDEN NAME <u>Sarah A. Crabill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes</u> <u>W. W. II</u>		16. SOCIAL SECURITY NO. <u>225-28-0442</u>	
17. INFORMANT <u>Mrs. Deborah Jones-4104 Buckingham Rd. 21207</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1930</u> DUE TO <u>metastatic Malignant</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Melanoma of the Brain</u> (c) <u> </u> DUE TO <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>undetermined</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-19, 1967</u> , to <u>5-12, 1967</u> that (I) (we) last saw the deceased alive on <u>5-12, 1967</u> and that death occurred at <u>8:45 AM</u> , from causes and on the date stated above.		22a. SIGNATURE <u>RUPERT MANANKIL</u>	
22c. PHYSICIAN'S NAME (Type) <u>RUPERT MANANKIL</u>		22b. DATE SIGNED <u>5-12-67</u>	
22d. ADDRESS <u>Baltimore County Gen. Hosp.</u>		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/15/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Meadow Ridge Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Wash. Blvd & Dorsey Rd. Md.</u>	
24. FUNERAL DIRECTOR <u>Loring Byers</u>		25a. REC'D BY REGISTRAR <u>MAY 15 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS	

Baltimore County

2-15-2

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Memoranda of the Board
of Directors

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06320

CERTIFICATE OF DEATH

06310

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Balt.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 30.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		d. STREET ADDRESS 833 W. Lombard St.	
3. NAME OF DECEASED (Type or print) First ARNOLD Middle Miller Last JUSTICE		4. DATE OF DEATH Month MAY Day 7 Year 19 67	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-17-12
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY Box Factory	
11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.G.	
13. FATHER'S NAME William Justice		14. MOTHER'S MAIDEN NAME EMMA RUBENCOUNY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-10-0916	
17. INFORMANT Records, Mount Wilson State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4341 Congestive heart failure DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0021 Pulmonary tuberculosis - ASTHMA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE Wm. Newcomer		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/11/67	
23c. NAME OF CEMETERY OR CREMATORY Louder Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR Walters Funeral Home Pratt & Strickland		25a. REC'D BY REGISTRAR MAY 10 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

00310

REQUIRE TO READ

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REQUIRE TO READ

00310

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

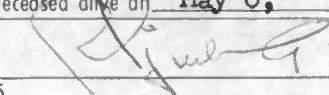

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06321

06311

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN b 30.4 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21212 d. STREET ADDRESS 626 Glenwood Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary D KANE				4. DATE OF DEATH Month Day Year May 6, 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH September 3, 1914	
9. AGE (In years lost birthday) 52 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME George Ditttrich				14. MOTHER'S MAIDEN NAME Anna M. Durrbeck			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-10-4942		17. INFORMANT Family Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic coma DUE TO (b) Portal cirrhosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 5810						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 18, 19 67 , to May 6, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 6, 19 67 , and that death occurred at 1:25PM , from causes and on the date stated above.							
22a. SIGNATURE 				22b. DATE SIGNED May 6, 1967		22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez	
22d. ADDRESS 7620 York Rd., Towson, Md. 21204				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22f. DATE MAY 9 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/10/67		23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEM		23d. LOCATION (City or Town) (County) (State) BALTIMORE MD	
24. FUNERAL DIRECTOR C.F. EVANS & SON 8802 Harford road				25a. REC'D BY REGISTRAR MAY 9 1967			
25b. REGISTRAR'S SIGNATURE 				25c. REGISTRAR'S NAME Charles Judge			

1150

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06322

CERTIFICATE OF DEATH

06312

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY IN 1b 9 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt 1, Box 34B Millersville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS Dogwood Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BERNARD GOODMAN KEIRSEY SR.				4. DATE OF DEATH Month Day Year MAY 24 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/15/1896		9. AGE (In years last birthday) yrs. 70	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper Hanger		10b. KIND OF BUSINESS OR INDUSTRY Paper Hanging		11. BIRTHPLACE (County & State, or foreign country) Petersburg, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter H. Keirsey				14. MOTHER'S MAIDEN NAME Mary E. Lucienberg			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 215-22-74-88		17. INFORMANT Address Clin.Rec. VAH, Fort Howard, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) THROMBOSIS OF ARTERIOSCLEROTIC CORONARY ARTERY DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH SECONDS UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 15, 1967 , to May 24, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 24, 1967 , and that death occurred at 6:00PM from causes and on the date stated above.							
22a. SIGNATURE <i>Alfonso Lopez</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/24/67	
22c. PHYSICIAN'S NAME (Type) ALFONSO LOPEZ, M.D.				22d. ADDRESS V.A.HOSPITAL, FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 29, 1967		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR R.V.SINGLETON FUNERAL HOME GLEN BURNIE, MD.				25a. REC'D BY REGISTRAR MAY 26 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06323

CERTIFICATE OF DEATH

06313

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 2255 Reisterstown Road			
3. NAME OF DECEASED (Type or print) First CHARLES Middle BROWN Last KELLER				4. DATE OF DEATH Month May Day 13 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 10/28/94		9. AGE (In years lost birthday) yrs. 72	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Monotype Operator				10b. KIND OF BUSINESS OR INDUSTRY Newspapers		11. BIRTHPLACE (County & State, or foreign country) Littleton, Pa.	
13. FATHER'S NAME Charles B. Keller				14. MOTHER'S MAIDEN NAME Lucinda King			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 1				16. SOCIAL SECURITY NO. 217 09 42 79		17. INFORMANT Clinical Rcds VA Hospital, Fort Howard, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 493X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) CARCINOMA OF ESOPHAGUS DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Days Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic vascular Heart Disease-Congestive Heart Failure						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 4 , 1967, to May 13 , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 13 , 1967, and that death occurred at 1:20M , from causes and on the date stated above.							
22a. SIGNATURE Alfonso A. Lopez Jr.				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/13/67	
22c. PHYSICIAN'S NAME (Type) ALFONSO A. LOPEZ, M.D.				22d. ADDRESS VA Hospital, Fort Howard, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/17/1967		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Wm. J. Tickner & Sons Tickner Funeral Home				25a. REC'D BY REGISTRAR May 16 1967		25b. REGISTRAR'S SIGNATURE Charles J. Jago	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06324

06314

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 78 DAYS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS BOX 1071B			
3. NAME OF DECEASED (Type or print) First HARRY Middle C. Last KELLNER				4. DATE OF DEATH Month MAY Day 26 Year 19 67			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/30/95	
9. AGE (In years last birthday) 72 yrs.		10. KIND OF BUSINESS OR INDUSTRY PLUMBING SHOP		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER				13. FATHER'S NAME OSCAR KELLNER			
14. MOTHER'S MAIDEN NAME MINNIE MN: UNKNOWN				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I			
16. SOCIAL SECURITY NO. 215 10 66 85				17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PAPILLARY NECROSIS KIDNEYS, BILATERAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PULMONARY EDEMA (c) ARTERIOSCLEROTIC HEART DISEASE							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN RECENT
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DIABETES MELLITUS, CLINICAL							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 3/9/67 , 19__ to 5/26/67 , 19__, that (X) (we) last saw the deceased alive on 5/26/67 , 19__, and that death occurred 6:15 AM , from causes and on the date stated above.							
22a. SIGNATURE <i>Jorge A. Fabara</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/26/67	
22c. PHYSICIAN'S NAME (Type) JORGE A. FABARA, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-29-67		23c. NAME OF CEMETERY OR CREMATORY CAMP CHAPEL CEMETERY		23d. LOCATION (City or Town) (County) (State) JOPPA RD. PERRY HALL, MD.	
24. FUNERAL DIRECTOR LASSAARD FUNERAL HOME 47401 Belair Road, Baltimore, Md.				25a. REC'D BY REGISTRAR MAY 29 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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4580

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 Items #2c & d Film #G389 6/2/67 pc
CERTIFICATE OF DEATH

06325

06315

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN TB			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville Balto. 21229	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summit Nursing Home -98 Smithwood Ave.				d. STREET ADDRESS Summit Nursing Home 609 Stamford Rd. 98 Smithwood Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle Marie Last Kelly				4. DATE OF DEATH Month May Day 18 Year 19 67			
5. SEX F	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 4/20/88		9. AGE (In years last birthday) yrs. 79	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Late - Joseph McCurnin				14. MOTHER'S MAIDEN NAME Late - Mary ---			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Marie Kelly Snyder Address 609 Stamford Rd. - 21229			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis with Chronic Brain Syndrome 444X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Essential Hypertension							INTERVAL BETWEEN ONSET AND DEATH 1 yr.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Oct. , 19 51 , to May , 19 67 , that (I) (we) last saw the deceased alive on May 16 , 19 67 , and that death occurred at 6:10 PM , from causes and on the date stated above.							
22a. SIGNATURE <i>Lee J. Gaver</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 19, 1967	
22c. PHYSICIAN'S NAME (Type) Lee J. Gaver, M.D.				22d. ADDRESS 1 Mallow Hill Road			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/22/67		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.				25a. REC'D BY REGISTRAR DATE MAY 22 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03315

03315

Signature

Catonsville

Domestic Building House - 18 Catonsville Ave.
Catonsville, Md.

Anna

Marie

Emily

May 12

Good

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Higginville

New Tarry

also - Joseph. K. Brown

also - Mary

also - Mrs. J. L. Brown
also - Mrs. J. L. Brown

also - Mrs. J. L. Brown

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also - Mrs. J. L. Brown

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06326

Item 3 Film 6389 5/26/67 kk
CERTIFICATE OF DEATH

06316

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville			c. LENGTH OF STAY IN 1b 50 yr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3009 6th Ave.				d. STREET ADDRESS 3009 6th Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HOWARD E KEMMERLY Kemmerly				4. DATE OF DEATH Month May Day 22 Year 1967			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 15 1885	
				9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motorman				10b. KIND OF BUSINESS OR INDUSTRY Balto Transit		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Lazarus Kemmerly				14. MOTHER'S MAIDEN NAME Esther Ford			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-10-2995		17. INFORMANT Family Records Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis CVD e Myocardial Infarction DUE TO (b) Coronary artery DUE TO (c) 1201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 5 yr 1 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6 Apr , 19 67 , to 22 May , 19 67 , that (I) (we) last saw the deceased alive on 22 May , 19 67 , and that death occurred at 4 PM , from causes and on the date stated above.							
22a. SIGNATURE Howard Goodman				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 23 May 67	
22c. PHYSICIAN'S NAME (Type) Howard Goodman				22d. ADDRESS 8604 Harford road			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/26/67		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION (City or Town) (County) (State) Balto Md.	
24. FUNERAL DIRECTOR C.F. EVANS & SON 8802 Harford Rd.				25a. REC'D BY REGISTRAR DATE MAY 24 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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VR A15 (4)
20 M 1/66

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1

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06327

CERTIFICATE OF DEATH

06317

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fork</u>				c. LENGTH OF STAY IN 1b <u>25 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 30 Fork Rd.</u>				d. STREET ADDRESS <u>Box 30 Fork Rd Baldwin</u>			
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Kendrick</u> Last <u>Kendrick</u>				4. DATE OF DEATH Month <u>5</u> Day <u>4</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-24-1898</u>	9. AGE (In years last birthday) <u>76</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Hungary</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>John Peterhawk</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Denasco</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Mr George Taylor Box 30 Baldwin Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular</u> 334 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arteriosclerosis</u> DUE TO (c) <u>Diabetes mellitus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 yrs</u> <u>10 yrs</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>8/24</u> , 19 <u>65</u> , to <u>5/4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/3</u> , 19 <u>67</u> , and that death occurred at <u>4</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Clifford F. Hudson</u>				22b. DATE SIGNED <u>5/4</u>		22c. PHYSICIAN'S NAME (Type) <u>CLIFFORD F HUDSON</u>	
22d. ADDRESS <u>FORK MD</u>				22e. ADDRESS <u>FORK MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>5-6-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem</u>	
23d. LOCATION (City or Town) (County) (State) <u>Baltimore</u>				23e. LOCATION (City or Town) (County) (State) <u>Baltimore Md</u>			
24. FUNERAL DIRECTOR <u>Lassahn Funeral Home 7401 Belair Road</u>				25a. REC'D BY REGISTRAR <u>DATE MAY 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06328

CERTIFICATE OF DEATH

06318

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b 03.1		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21221		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 608 N. Woodward Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hilton Middle B. Last King				4. DATE OF DEATH Month May Day 15 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-31-10		9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months 57 Days 15 Hours 03 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) receiving dept.		10b. KIND OF BUSINESS OR INDUSTRY Food		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 212-09-7523		17. INFORMANT Address 21221 Mrs. Eleanora King, 608 Northwood Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X Ruptured Abdominal Aneurysm DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 15 , 19 67 to May 15 , 19 67 , that (I) (we) last saw the deceased alive on May 15 , 19 67 , and that death occurred at 10:58 M, from causes on and on the date stated above.							
22a. SIGNATURE Juan Gan				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED May 15, 1967	
22c. PHYSICIAN'S NAME (Type) Juan Gan M.D.				22d. ADDRESS 7620 York Road - Towson 21204, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 5-18-67		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		23d. LOCATION (City or Town) (County) (State) Baltimore County, Md.	
24. FUNERAL DIRECTOR Ullrich Funeral Home, Baltimore, Md.				25a. REG. BY REGISTRAR MAY 22 1967		25b. REGISTRAR'S SIGNATURE Francis Judge	

81230

HEAD OF THE DEATH

22830

[Faint, mostly illegible text covering the page, likely bleed-through from the reverse side. Some words like "HEAD OF THE DEATH" are visible.]

VR A15 (4)
20 M 1/66

30

MEDICAL CERTIFICATION

<div style="display: flex; justify-content: space-between;"> MARYLAND STATE DEPARTMENT OF HEALTH 06319 </div> <div style="text-align: center;"> Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN lb <u>5 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Agnes Women's & Men's Home</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>-</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>619 E. 33rd Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Mrs Louise Saunders Kriebelberg</u>				4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1967</u>				5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>12-8-1892</u> 9. AGE (In years last birthday) <u>74</u> yrs. <div style="display: flex; justify-content: space-between;"> <div>IF UNDER 1 YEAR</div> <div>IF UNDER 24 HRS.</div> </div>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dep't of Motor Vehicles</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>Richmond, Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						13. FATHER'S NAME <u>John Henry Bramberry</u> 14. MOTHER'S MAIDEN NAME <u>Adelaide Gouldman</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>213-18-7793</u> 17. INFORMANT <u>Daisy E. Hamilton</u> Address <u>Towson</u> <u>615 Chestnut Ave</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure (terminal)</u> DUE TO (b) <u>Acute pulmonary edema, bilateral</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>15 MI.</u> <u>1 day.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic arteriosclerotic, cardio-vascular syndrome</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 14, 1962</u> , to <u>May 19, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 19, 1967</u> , and that death occurred at <u>4:45 AM</u> , from causes and on the date stated above.											
22a. SIGNATURE <u>Edwin B. Jarrett</u>						22b. DATE SIGNED <u>5/19/67.</u>				22c. PHYSICIAN'S NAME (Type) <u>Edwin B. Jarrett, M.D.</u>	
22d. ADDRESS <u>11 East Chase St., City-2.</u>						22e. ATTENDING PHYS. <input checked="" type="checkbox"/> 22f. MED. DIRECTOR <input type="checkbox"/> 22g. STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF <u>May 20, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Crematory</u>				23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, 1050 York Rd., 21204</u>						25. RECEIVED BY REGISTRAR <u>MAY 22 1967</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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NEWS!

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Mr. [illegible]

1959

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Female white

Sept. 8, 1908

Richard, Virginia

John Henry Brambley, Adelaide, Australia

213-18-7793 Xany E. Chumbebe, aka Chastany Xany

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06330

CERTIFICATE OF DEATH

06320

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. LENGTH OF STAY IN TB
DOA | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
GREATER BALTIMORE MEDICAL CENTER | | d. STREET ADDRESS
1308 WOODBURNE AV | |
| 3. NAME OF DECEASED
(Type or print) EDGAR First Middle Last KNAUFF SR. | | 4. DATE OF DEATH
Month 5 Day 10 Year 1967 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 11, 1891 |
| 9. AGE (In years last birthday)
75 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Ret.-Bldg. Inspector Housing Auth. | | 10b. KIND OF BUSINESS OR INDUSTRY
BALTIMORE | |
| 11. BIRTHPLACE (County & State, or foreign country)
BALTIMORE BALT. Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
William G. Knauff | | 14. MOTHER'S MAIDEN NAME
Nannie McIlvain | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
215-05-2625 | |
| 17. INFORMANT
HUGH KNAUFF | | Address
1357 NORTHERN PKWY | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO Generalized Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus
(c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Sept , 19 64 , to May 10 , 19 67 , that (I) (we) last saw the deceased alive on 4/26 , 19 67 , and that death occurred at 11 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Charles F. Fravel | | 22b. DATE SIGNED
5/10/67 | |
| 22c. PHYSICIAN'S NAME (Type)
C. Richard Fravel | | 22d. ADDRESS
Medical Arts Bldg., Balto., Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
5/13/1967 | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood | 23d. LOCATION (City or Town) (County) (State)
Parkville, Balto. Co., Md. |
| 24. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. | | 25. REC'D BY REGISTRAR
MAY 12 1967 | |
| ADDRESS
4905 York Rd. Balto. 12, Md. | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06331

CERTIFICATE OF DEATH

06321

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Greater Baltimore Medical Center</u>
<u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY _____ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>BALTIMORE</u> | | c. LENGTH OF STAY IN TB
<u>5 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>GREATER BALTIMORE MEDICAL CENTER</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>WALTER</u> Middle <u>PHILLIP</u> Last <u>KRAETER</u> | | 4. DATE OF DEATH
Month <u>MAY</u> Day <u>1st</u> Year <u>1967</u> | |
| 5. SEX
<u>MALE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>12.28.01</u> |
| 9. AGE (In years lost birthday)
<u>65</u> yrs. | | 10. IF UNDER 1 YEAR
Months _____ Days _____ Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>ELECTRICIAN</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>RETIRED</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>BALTIMORE, MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>PHILLIP KRAETER</u> | | 14. MOTHER'S MAIDEN NAME
<u>KOHLOPPE</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>220-30-1568</u> | |
| 17. INFORMANT
<u>PPS HISTORY</u> | | Address _____ | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>
<u>4201</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 days</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour _____ a.m. _____ p.m. _____ 19 _____ | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4.27.1967</u> , to <u>5.1.1967</u> , that (I) (we) lost the deceased alive on <u>5.1.1967</u> , and that death occurred at <u>12:45A</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>M. Usha Kumari</u> M.D. | | 22b. DATE SIGNED
<u>5.1.67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Dr. L. SERRA M. USHA KUMARI</u> | | 22d. ADDRESS
<u>6701 NORTH CHARLES STREET - BALTIMORE, MARYLAND</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>5/4/67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Holy Redeemer Cemetery</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Md.</u> |
| 24. FUNERAL DIRECTOR
<u>Schimunek Funeral Home, Inc.</u>
<u>3331 Brehms Lane</u> | | 25a. REC'D BY REGISTRAR
<u>MAY 2 1967</u> | 25b. REGISTRAR'S SIGNATURE
<u>J. Charles Judge</u> |

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TO HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|--|--|----------------------------------|--|---|---|---|------|---|--|--|--|
| <div style="display: flex; justify-content: space-between;"> 06332 Item #8 Film #0388 5/15/67 06322 </div> | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
Baltimore | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Howard | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Catonsville | | | | | c. LENGTH OF STAY IN 1b
MARYLAND | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Summit Nursing Home, 98 Smithwood Ave. | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Ellicott City | | | | | | |
| d. STREET ADDRESS
93 Bali Road | | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
Dora | | | First | | Middle | | Last | | 4. DATE OF DEATH
Month May Day 8 Year 1967 | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1884
May 20, 1884 | | 9. AGE (in years last birthday)
82 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Work in Bakery | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Bakery | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | | | 12. CITIZEN OF WHAT COUNTRY?
US | | |
| 13. FATHER'S NAME
Late Frederick Schmelz | | | | | 14. MOTHER'S MAIDEN NAME
Margaret | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
no | | | | 16. SOCIAL SECURITY NO.
214-10-0490A | | 17. INFORMANT
Mr. Frank M. Krantz, 107 McAlpine Rd., Ellicott City | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY THROMBOSIS, ACUTE
4201 DUE TO (b) MYOCARDIAL INFARCTION, RECENT
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) ARTERIOSCLEROSIS
INTERVAL BETWEEN ONSET AND DEATH
5 WEEKS
10 YEARS | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 10/23, 1966 to 5/8, 1967 , that (I) (we) last saw the deceased alive on 5/5, 1967 , and that death occurred at 7:30 AM , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Paul R. Ziegler | | | | | | 22b. DATE SIGNED
5/8/67 | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
Paul R. Ziegler | | | | | | 22d. ADDRESS
200 Chestnut Hill Dr., Ellicott City, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE THEREOF
May 11, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
London Park | | | 23d. LOCATION (City, town or county) (State)
Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR
Harry H. Witzke, 321 Columbia Pike, Ellicott City, Maryland | | | | | | 25a. REC'D BY REGISTRAR
MAY 9 1967 | | | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

MEDICAL CERTIFICATION

5520

88320

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | |
|--|--|----------------------------------|---|---|--|--|--------------------------------------|---|--|---|--|--------------------------------|--|--|
| 06333 | | | | | CERTIFICATE OF DEATH | | | | | 06323 | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Dundalk</u> | | | c. LENGTH OF STAY IN 1b
<u>4 Months</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Dundalk</u> | | | | | d. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>1835 Portship Road</u> | | | | | d. STREET ADDRESS
<u>1835 Portship Road</u> | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<u>Mabel May Krantz</u> | | | | | 4. DATE OF DEATH
Month Day Year
<u>May 2 1967</u> | | | | | | | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>9/24/98</u> | | 9. AGE (In years last birthday)
<u>68</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Virginia</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | |
| 13. FATHER'S NAME
<u>Louis Lanham</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Ida Belle Wright</u> | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> | | | 16. SOCIAL SECURITY NO.
<u>213-30-4334</u> | | 17. INFORMANT (Son)
<u>Melvin Krantz, 7124 Crestshire Rd. Dundalk,</u> | | | | | Address <u>Maryland 21222</u> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Adenocarcinoma of abdominal cavity</u>
<u>1750</u> DUE TO <u>Severely metastatic, probably originated from ovaries</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO
(c) DUE TO | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>5 months</u> | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
<u>19</u> | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 15</u> , 19 <u>65</u> , to <u>May 2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>April 28</u> , 19 <u>67</u> , and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above. | | | | | | | | | | | | | | |
| 22a. SIGNATURE
<u>Ataollah Golpira</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22b. DATE SIGNED
<u>5/2/67</u> | | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Ataollah Golpira</u> | | | | | 22d. ADDRESS
<u>M.D. 1942 Cedar Lane, Dundalk, Md. 21222</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | 23b. DATE THEREOF
<u>5/5/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Gardens of Faith Cemetery</u> | | | | 23d. LOCATION (City, town or county) (State)
<u>Baltimore, Maryland</u> | | | | | |
| 24. FUNERAL DIRECTOR
<u>John J. Duda, 7922 Wise Ave. Dundalk, Md. 21222</u> | | | | | 25a. REC'D BY REGISTRAR
<u>MAY 4 1967</u> | | | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06334

CERTIFICATE OF DEATH

06324

| | | | | | | | |
|---|----------------------------------|---|--|--|--------------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Towson MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | c. LENGTH OF STAY IN TB
17 days | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 21218 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
GREATER BALTIMORE MEDICAL CENTER | | | | d. STREET ADDRESS
1655 Argonne Drive | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Harrietta | | First Middle Last
N.M.N. Kress | | 4. DATE OF DEATH
Month May Day 24 Year 19 67 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2/1/1884 | 9. AGE (In years last birthday)
83 yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
William Simmons | | | | 14. MOTHER'S MAIDEN NAME
Price, Harrietta | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
217-30-4984 | | 17. INFORMANT Address
Mr. Richard Simmons Same as patient | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____
DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 5/8/ , 19 67 , to 5/24 , 19 67 , that (I) (we) last saw the deceased alive on 5/24 19 67 , and that death occurred at 2:55pm , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE John E. Adams | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
5/24/67 | |
| 22c. PHYSICIAN'S NAME (Type)
John E. Adams, M. D. | | | | 22d. ADDRESS
Greater Baltimore Medical Center | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/27/67. | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 | | | | 25a. REC'D BY REGISTRAR
MAY 29 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles J. [Signature]</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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OFFICE IN CHARGE

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06335

CERTIFICATE OF DEATH

05325

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|---|----------------------------------|---|---|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | | c. LENGTH OF STAY IN 1b | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | | | d. STREET ADDRESS
8219 Belair Road | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
JAMES A. KROLL | | | | 4. DATE OF DEATH
Month May Day 30 Year 1967 | | | |
| 5. SEX.
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
April 1, 1894 | | 9. AGE (In years last birthday)
73 yrs. | 10. IF UNDER 1 YEAR
Months Days Hours Min. | 11. IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
? | | | | 14. MOTHER'S MAIDEN NAME
? | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes | | 16. SOCIAL SECURITY NO.
212-14-8489 | | 17. INFORMANT
Dagmar Ritzman, | | Address
Same as # 2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute coronary thrombosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio-sclerotic heart dis.
DUE TO
(c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Instant
5 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Sept , 1960, to 5-30 , 1967 that (I) (we) last saw the deceased alive on 5-4 , 1967, and that death occurred at 3:15 AM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Wm. Wong | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
M.D. | | 22b. DATE SIGNED
6-1-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Wm. Wong | | | | 22d. ADDRESS
6801 BELAIR RD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
June 3, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Wiesburg Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204 | | | | 25a. REC'D BY REGISTRAR
DATE JUN 5 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06336

06326

FOR STATE HEALTH DEPT.

| | | | |
|---|-------------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Randallstown | | c. LENGTH OF STAY IN ID
4 yrs | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
9716 Tulsemere Road | | d. STREET ADDRESS
9716 Tulsemere Road | |
| 3. NAME OF DECEASED (Type or print)
First ROBERT Middle LEE Last KRUSENKLAUS | | 4. DATE OF DEATH
Month May Day 19 Year 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/25/31 |
| 9. AGE (In years last birthday)
35 yrs. | | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY
Gen Elec Supply | 11. BIRTHPLACE (State or foreign country)
Kentucky |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
John Krusenklous | |
| 14. MOTHER'S MAIDEN NAME
Helen Carr | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
yes wwii | |
| 16. SOCIAL SECURITY NO.
400-38-1755 | | 17. INFORMANT
Betty Jo Krusenklous | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gunshot wound of head
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.
about 6:00 p.m. 5-19 1967 | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Shot welf in head | |
| 20c. TIME OF INJURY Month, Day, Year
about 6:00 p.m. 5-19 1967 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
home | | 20f. (City or town) (County) (State)
Baltimore Md. | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Charles S. Springate | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
Charles S. Springate, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22. DATE SIGNED
May 20, 1967 | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| Address (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
5/23/67 | 23c. NAME OF CEMETERY OR CREMATORY
Calvary | 23d. LOCATION (City or Town) (County) (State)
Louisville Jefferson Ky. |
| 24. FUNERAL DIRECTOR
Living Byers | | 25a. REC'D BY REGISTRAR
MAY 22 1967 | |
| Address
8728 Liberty Rd Randallstown Md | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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06327

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
27yr3mth7days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Spring Grove State Hospital | | d. STREET ADDRESS 1227 Glyndon Street | |
| 3. NAME OF DECEASED (Type or print)
First Mary Middle Kuszlis Last Kuszlis | | 4. DATE OF DEATH
Month May Day 16 Year 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
Jan. 30, 1891 |
| 9. AGE (In years last birthday) yrs.
76 | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Factory worker | | 10b. KIND OF BUSINESS OR INDUSTRY
Sailor Shop | |
| 11. BIRTHPLACE (County & State, or foreign country)
Lithuania | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Maichael Kaiser | | 14. MOTHER'S MAIDEN NAME
Antoinette Sherpenskas | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
215-05-8037 | |
| 17. INFORMANT
Records: Spring Grove State Hospital | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary emboli
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
6 to 8 hrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 9, 1939 to May 16, 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 16, 19 67 , and that death occurred at 3:55 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Anthony J. Young, M.D. | | 22b. DATE SIGNED
5-17-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Anthony J. Young, M.D. | | 22d. ADDRESS
Spring Grove State Hospital
Baltimore, Maryland 21228 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/20/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cem. | | 23d. LOCATION (City or town) (County) (State)
4436 Belair Rd. Md. | |
| 24. FUNERAL DIRECTOR
John J. Loman & Son Inc. | | 25a. REC'D BY REGISTRAR
MAY 18 1967 | |
| ADDRESS
901 Hollins St.
B3, Md. | | 25b. REGISTRAR'S SIGNATURE
Charles J. Jones | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06338

CERTIFICATE OF DEATH

06328

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|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Ma ryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
RURAL Baltimore City | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
RURAL Baltimore City 03-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
221 Bowleys Quarters Road | | d. STREET ADDRESS
221 Bowleys Quarters Road | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) A N T H O N Y First L A G N A Middle L A G N A Last | | 4. DATE OF DEATH
Month May Day 8 Year 19 67 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan. 17, 1888 |
| 9. AGE (In years last birthday) 79 yrs. | | 10. IF UNDER 1 YEAR
Months 79 Days 79 Hours 79 Min. 79 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
cement finisher, retired | | 10b. KIND OF BUSINESS OR INDUSTRY
Italy | |
| 11. BIRTHPLACE (County & State, or foreign country)
Italy | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
? Lagna | | 14. MOTHER'S MAIDEN NAME
Dominica ? | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
214-01-2010 | |
| 17. INFORMANT
Mrs. Rose Martin--221 Bowleys Quarters Rd.--20 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Colon
1538 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastasis To Liver
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
Jan 1967
11 1967 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Sept , 19 64 , to May 8 , 19 67 , that (I) (we) last saw the deceased alive on May 8 , 19 67 , and that death occurred at 8:30 M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
John W. Ashworth | | 22b. DATE SIGNED
5/9/67 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. John W. Ashworth | | 22d. ADDRESS
1129 St. Paul St., Balto., Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | 23b. DATE THEREOF
5/12/67. | |
| 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc.--Baltimore, Md.--14 | | 25a. REC'D BY REGISTRAR
MAY 10 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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DIRECTOR

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06339

CERTIFICATE OF DEATH

06329

| | | | | | | | | | |
|---|--|---|-----------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | | c. LENGTH OF STAY IN 1b
 | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Shady Nook Nursing Home | | | | | | d. STREET ADDRESS
2409 Annapolis Rd. 21230 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) Mynard First E. Middle Lake Last | | | | 4. DATE OF DEATH
Month May Day 28 Year 1967 | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
2/17/85 | | 9. AGE (In years last birthday) 82 yrs.
IF UNDER 1 YEAR: Months _____ Days _____
IF UNDER 24 HRS.: Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Financial Secretary | | | | 10b. KIND OF BUSINESS OR INDUSTRY
IUOE | | 11. BIRTHPLACE (County & State, or foreign country)
New Jersey | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Edwin Lake | | | | | | 14. MOTHER'S MAIDEN NAME
Catherine Maney | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
212-10-6176 | | 17. INFORMANT Address 21230
Mrs. Dorothy M. Orem 2409 Annapolis Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) arteriosclerotic cardiovascular disease
DUE TO _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____
DUE TO _____
(c) _____ | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
6 months + | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Diabetes Mellitus | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>March 28, 1967</u>, to <u>May 28, 1967</u>, that (I) (we) last saw the deceased alive on <u>May 28, 1967</u>, and that death occurred at <u>10 P.M.</u> from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<i>John A. Nesbitt Jr.</i> | | | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
5-31-67 | |
| 22c. PHYSICIAN'S NAME (Type)
John A. Nesbitt Jr. | | | | | | 22d. ADDRESS
1009 Frederick Road | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
6/1/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard | | | | ADDRESS
4107 Wilkens Ave. 21229 | | 25a. REC'D BY REGISTRAR
JUN 2 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06340

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05330

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk | | c. LENGTH OF STAY IN 1b
13-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
7245 Holabird | | d. STREET ADDRESS 7245 Holabird Ave | |
| 3. NAME OF DECEASED (Type or print)
William R Lane | | 4. DATE OF DEATH May 6 / 67 | |
| s. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 16 1914 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Foreman Steel | | 10b. KIND OF BUSINESS OR INDUSTRY Beth Steel | |
| 13. FATHER'S NAME William Lane | | 14. MOTHER'S MAIDEN NAME Penna Nell O Toole | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Terry P Lane | | Address 7245 Holabird Ave | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension C-V-Disease
DUE TO
(c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
None | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE M B Davis M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Melvin B Davis 6800 Morningson Road | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | | 23b. DATE THEREOF May 6/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY St Johns Cem | | 23d. LOCATION (City or Town) (County) (State) Scottsdale Pa | |
| 24. FUNERAL DIRECTOR Ullrich Funeral Home 2112 Dundalk Ave Dundalk | | 25a. REC'D BY REGISTRAR 5/11/67 25b. John P. Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in no event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06341

CERTIFICATE OF DEATH

06331

| | | | | | | | |
|---|------------------------------|--|------------------------------------|--|---|--|--------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTO</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>BALTO</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CATONSVILLE</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CATONSVILLE</u> 03.1 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>11 NEWBURG AVE</u> | | | | d. STREET ADDRESS
<u>11 NEWBURG AVE</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>CATHERINE O. LANG</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>MAY 17 19 67</u> | | | |
| 5. SEX
<u>7</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED
<input type="checkbox"/> NEVER MARRIED
<input checked="" type="checkbox"/> WIDOWED
<input type="checkbox"/> DIVORCED | 8. DATE OF BIRTH
<u>9/29/81</u> | 9. AGE (In years last birthday)
<u>85</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
<u>MD.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>JOHN INGALLS</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>ALVERDIA JOHNSON</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT Address
<u>MRS. T. ALLAN MUIR</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4500 Uremia Dehydration</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic arteriosclerotic - severe</u>
DUE TO (c) <u>Chronic cardiac failure</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Home</u> | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>66</u> , to <u>17 May</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>17 May</u> , 19 <u>67</u> , and that death occurred at <u>6</u> M, from causes <u>as stated above</u> and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>William J. Bryson</u> | | | | 22b. DATE SIGNED
<u>18 May 67</u> | | 22c. PHYSICIAN'S NAME (Type)
<u>William J. Bryson</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>5/19/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>WESTERN</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>BALTO, MD.</u> | |
| 24. FUNERAL DIRECTOR ADDRESS
<u>E.S. MALNAB 301 FREDERICK RD 21228</u> | | | | 25a. REC'D BY REGISTRAR
<u>MAY 22 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>J. Charles Judge</u> | |

1833

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06342

05332

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | | | c. LENGTH OF STAY IN 1b <u>2 days</u> | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beyond Mill Road</u> | | | | d. STREET ADDRESS <u>Beyond Mill Road</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Brester Baltimore Medical Center</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>Lathe</u> | | | | 4. DATE OF DEATH Month <u>5</u> Day <u>12</u> Year <u>1967</u> | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>Can</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>5/21/1889</u> 78 yrs. | |
| 9. AGE (In years last birthday) <u>78</u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NA</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>NA</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Charles Lathe</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>113-03-9181</u> | | 17. INFORMANT Address <u>Patient Chart</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Vascular Disease</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive Heart Failure</u>
DUE TO
(c) <u>Acute myocardial infarction</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 10th</u> , 19 <u>67</u> , to <u>May 12th</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 12th</u> , 19 <u>67</u> , and that death occurred at <u>9:30 AM</u> , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>M. Isabelle MacGo...</u> | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED <u>5-12-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>DR. ROBERT ENSOR</u> | | | | 22d. ADDRESS <u>Old Baltimore Medical Center</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF <u>May 15, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Bernard Cemetery</u> | | 23d. LOCATION (City or Town) <u>Harrisonville, Md.</u> (County) (State) | |
| 24. FUNERAL DIRECTOR <u>Frank H. Newell</u> | | | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| DATE <u>MAY 16 1967</u> | | | | | | | |

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Mr. Charles Foster
Mr. William Foster

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06343

CERTIFICATE OF DEATH

06333

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|--|----------------------------------|---|--|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | c. LENGTH OF STAY IN 1b
20 Days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore, Maryland 21221 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Greater Baltimore Medical Center | | | | d. STREET ADDRESS
294 Stillwater Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First MARGARET Middle LEBRUN Last LEBRUN | | | | 4. DATE OF DEATH
Month May Day 11 Year 19 67 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7/16/07 | | 9. AGE (In years last birthday)
59 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore | | 12. CITIZEN OF WHAT COUNTRY?
America | |
| 13. FATHER'S NAME
Henry Fred Komber | | | | 14. MOTHER'S MAIDEN NAME
Beckhold | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Patient's History | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intestinal Obstruction
154X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Rectum DUE TO
(c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 Years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from April 22, 19 67 to May 11, 19 67 , that (I) (we) last saw the deceased alive on May 11, 19 67 , and that death occurred at 2:00 A.M. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
John E. Adams | | | | 22b. DATE SIGNED
5/11/67 | | 22c. PHYSICIAN'S NAME (Type)
John E. Adams, M.D. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/15/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | | 23d. LOCATION (City or Town) (County) (State)
Balto Md. | |
| 24. FUNERAL DIRECTOR
J. L. Connolly Son | | | | 25a. REC'D BY REGISTRAR
300 more | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

12338

MINISTRY OF DEFENSE

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John E. Allen

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH </div> | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville
c. LENGTH OF STAY IN 1b 2yr2mth28days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside, Maryland
d. STREET ADDRESS 1400 - 49th Avenue
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) Ethel Leigh
First Middle Last | | | | | 4. DATE OF DEATH May 8 1967
Month Day Year | | | | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Aug. 14, 1898 | | 9. AGE (In years last birthday) 68 yrs.
IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (County & State, or foreign country) Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY? U. S. | |
| 13. FATHER'S NAME Charles Hines | | | | | 14. MOTHER'S MAIDEN NAME Anna Leahy | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. 578-05-2575B | | 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO (b) Arteriosclerosis, Generalized, senile
UNDERLYING CAUSE (c) Hypertension; Left cerebral hemorrhage (2 yrs. ago). | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 years
10 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Hypertension; Left cerebral hemorrhage (2 yrs. ago). | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 10 1965 to May 8 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 8 1967, and that death occurred at 3:00 P.M. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <i>Anthony J. Young</i> | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> M.D. <input type="checkbox"/> M.E. <input type="checkbox"/> M.F. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 5-8-67 | | |
| 22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D. | | | | | 22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) 5-11-67 | | 23b. DATE THEREOF 5-11-67 | | 23c. NAME OF CEMETERY OR CREMATORY WASH. NAT'L PARK | | 23d. LOCATION (City, town or county) SUITLAND BLVD. CO. MD | | | |
| 24. FUNERAL DIRECTOR <i>W. H. Chambers Co.</i> 517 11th St. SE WASH. D.C. | | | | | 25a. REC'D BY REGISTRAR MAY 11 1967 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. After please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06345

CERTIFICATE OF DEATH

06335

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Overlea | | c. LENGTH OF STAY IN TB
16 Yrs. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
109 Manor Avenue | | d. STREET ADDRESS
109 Manor Avenue | |
| 3. NAME OF DECEASED (Type or print)
First Donald Middle F. Last Linch | | 4. DATE OF DEATH
Month May Day 17 Year 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
Caucasian | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 23 1909 |
| 9. AGE (In years last birthday)
57 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Superintendent | 11. BIRTHPLACE (County & State, or foreign country)
Buffalo, N. Y. |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Henry Linch | |
| 14. MOTHER'S MAIDEN NAME
Grace Curtin | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | |
| 16. SOCIAL SECURITY NO.
070-10-4665 | | 17. INFORMANT
Catherine M. Linch Address 109 Manor Avenue 21206 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease
DUE TO
(b) Congestive heart failure
DUE TO
(c) Aortic stenosis and mitral insufficiency | | | INTERVAL BETWEEN ONSET AND DEATH
at least 3 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (his hospital) attended the deceased from 1963 , 19____, to Death , 19____, that (I) (we) last saw the deceased alive on May 15 , 19 67 , and that death occurred at 2 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Crawford N. Kirkpatrick, Jr. | | 22b. DATE SIGNED
May 18, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Crawford N. Kirkpatrick M.D. | | 22d. ADDRESS
6 East Eager St. Balto. Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
May 20, 1967 | 23c. NAME OF CEMETERY OR CREMATORY
Sacred Heart Cemetery | 23d. LOCATION (City or Town) (County) (State)
Balto. Md. |
| 24. FUNERAL DIRECTOR
The Dippel Bro's Inc. | | 25a. REC'D BY REGISTRAR
MAV 10 1967 | |
| ADDRESS
7110 Belair Rd. | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH </div> | | | | | | | | | |
|---|--|--|--|--|--|---|---|--|--|
| 06346
1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Josephs Hospital | | | | | 06336
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Balto.
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 34
d. STREET ADDRESS 9322 Old Harford Rd.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) Olive Maria Longbottom
First Middle Last | | | 4. DATE OF DEATH 5 4 1967
Month Day Year | | 5. SEX F 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH March 4, 1883
9. AGE (In years last birthday) 84 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (County & State, or foreign country) Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME Samuel McClain
14. MOTHER'S MAIDEN NAME Sarah E. Gerber | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO. 220-48-2133 17. INFORMANT B. Bruce Longbottom Address Above | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-vascular renal dis
442X
DUE TO (b) Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
20 yrs
20 yrs | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) none | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 1944 to May 4, 1967 , that (I) (we) last saw the deceased alive on April 14, 1967 , and that death occurred at 7:25 PM , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE A. M. Bacon M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22b. DATE SIGNED 5/5/67 | | | | |
| 22c. PHYSICIAN'S NAME (Type) Dr. A. M. Bacon | | | | | 22d. ADDRESS 2810 Taylor Ave., Balto. 34, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood | | 23d. LOCATION (City, town or county) (State) Parkville Md. | | |
| 24. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd., Balto. 12, Md. | | | | | 25a. REC'D BY REGISTRAR 5 1967 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | |

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MARYLAND AND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06347

06337

| | | | | | | | |
|---|----------------------------------|---|---|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)
a. STATE Md. b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
606 Highland Ave. | | | | d. STREET ADDRESS
606 Highland Ave. | | | |
| 3. NAME OF DECEASED
(Type or print)
Susanne Lyness | | | | 4. DATE OF DEATH
Month May Day 23 Year 1967 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Oct. 4, 1896 | | 9. AGE (In years last birthday)
70 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
At Home | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Md. | |
| 13. FATHER'S NAME
James Myers | | | | 14. MOTHER'S MAIDEN NAME
Mary Gertrude McGuigan | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
161-09-6998 B | | | |
| 17. INFORMANT
Mr. Arthur A. Lyness, 606 Highland Ave. | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
DUE TO (b) Arteriosclerotic Heart Disease
DUE TO (c) Hypertensive Cardiovascular Disease
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
11/20/1 | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH
5 minutes
5 years
10 years | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (the hospital) attended the deceased from 5/11 to 5/23 , 1967, that (I) (we) last saw the deceased alive on 5/11 , 1967, and that death occurred at 3 A.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Robert T. Parker | | | | 22b. DATE SIGNED
May 23, 1967 | | 22c. PHYSICIAN'S NAME (Type)
ROBERT T. PARKER | |
| 22d. ADDRESS
SOUTH BALTO GENERAL HOSP. Balto 30 | | | | 22e. REC'D BY REGISTRAR
MAY 26 1967 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/26/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Cathedral Cemetery | | 23d. LOCATION (City, town or county) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
B. Vernon Lemmon | | | | 25. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

03233

03233

Salisbury

London

600 Highland Ave.

James Lane

White

Cot. A. 1896

Salisbury, Md.

At Home

James Lane

James Lane, Salisbury, Md.

61-0-692 H. H. Arthur A. Lane, 600 Highland Ave.

Central Library

2750

Salisbury

1011 Park Heights Ave. Balto.

May 30 1961

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
06348
CERTIFICATE OF DEATH
06338

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
St. Joseph Hospital | | | | d. STREET ADDRESS
329 Hillen Rd. 21204 | | | |
| 3. NAME OF DECEASED (Type or print)
First Charles Middle E. Last Mack | | | | 4. DATE OF DEATH
Month May Day 27 Year 1967 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
11-14-22 | |
| 9. AGE (In years last birthday)
44 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Unemployed | | | | 10b. KIND OF BUSINESS OR INDUSTRY
none | | 11. BIRTHPLACE (County & State, or foreign country)
ind. | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | 13. FATHER'S NAME
Edward Mack | | | |
| 14. MOTHER'S MAIDEN NAME
Bessie Watkins | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | | |
| 16. SOCIAL SECURITY NO.
unknown | | | | 17. INFORMANT
Edward Mack Address 325 Linnvale Ave. Towson | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Severe Cirrhosis of the liver
5810 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malnutrition
DUE TO (c) Cardiac failure | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from May 26 , 19 67 , to May 27 , 19 67 , that (I) (we) last saw the deceased alive on May 27 , 19 67 , and that death occurred at 6:45 PM on the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Benjamin Del Carmen | | | | 22b. DATE SIGNED
5-27-67 | | 22c. PHYSICIAN'S NAME (Type)
Benjamin Del Carmen | |
| 22d. ADDRESS
7620 York Rd. Baltimore, Md. 21204 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF
5/31/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Pleasant Rest | | 23d. LOCATION (City, town or county) (State)
Towson, Balto. Co. Md. | |
| 24. FUNERAL DIRECTOR
W. L. Chastman | | | | 25a. REC'D BY REGISTRAR
MAY 31 1967 | | 25b. REGISTRAR'S SIGNATURE
Richard S. Judge | |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 9 Film G389 5/25/67 KK
06349 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06339

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Baltimore Md. b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
TOWSON Baltimore | | | | c. LENGTH OF STAY IN 1b
Baltimore, Maryland 03/1 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Saint Joseph Hospital | | | | d. STREET ADDRESS Dartmouth 134 Dartmouth Ave | | | |
| 3. NAME OF DECEASED (Type or print)
First Joseph Middle I Last Mackin | | | | 4. DATE OF DEATH
Month May Day 21 Year 1967 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1907 59 80 AGE (In years last birthday) yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
Auto Supply | | 11. BIRTHPLACE (State or foreign country)
BALTO Md | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
James Mackin | | | | 14. MOTHER'S MAIDEN NAME
Mary McKay | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
Yes WW II | | | | 16. SOCIAL SECURITY NO.
210-07-129 | | 17. INFORMANT
Fam. Lg. Records | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 260X DUE TO Cerebral Occlusion Sudden
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Wegener's Malnutrition DUE TO 5+ years
(c) Arteriosclerotic Cardiovascular Disease | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. None | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Charles F. O'Donnell | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | Address (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or town) (County) (State) | |
| BURIAL | | 5-25-67 | | BALTIMORE National | | BALTO Md | |
| 24. FUNERAL DIRECTOR
C. F. EVANS | | | | ADDRESS
8802 Hartford Rd | | 25a. REC'D BY REGISTRAR
MAY 23 1967 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
gcharles Judge | | 22. DATE SIGNED
5/21/67 | |

02330

02330

The following information was obtained from the records of the Department of the Interior, Bureau of Land Management, for the year 1964.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06350

CERTIFICATE OF DEATH

06340

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE Maryland b. COUNTY Pr. Geo. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN Tb 4 mos. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Shangri-La Nursing Home | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) Frank R. Malzone | | 4. DATE OF DEATH
Month 5 - Day 10 - Year 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1/20/1896 |
| 9. AGE (In years last birthday) 71 yrs. | | 10. IF UNDER 1 YEAR
Months 5 Days 10 Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
U.S. Govt. | |
| 11. BIRTHPLACE (County & State, or foreign country)
Penna. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Joseph Malzone | | 14. MOTHER'S MAIDEN NAME
Dalton | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
386-12-3621 | |
| 17. INFORMANT
Mrs. Mary Lila Malzone (above address) | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intractable Congestive Heart Failure (wife)
DUE TO (b) Old Myocardial Infarction
DUE TO (c) ASCVD | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. 19
p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 1-10-1967 , to 5-10-1967 , that (I) (we) last saw the deceased alive on 5-10-1967 , and that death occurred at 9 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Cesar Valle Caverio | | 22b. DATE SIGNED
5-10-67 | |
| 22c. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERIO | | 22d. ADDRESS
7629 Liberty Rd | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
5/13/67 | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cem. | 23d. LOCATION (City or Town) (County) (State)
Silver Spring, Md. |
| 24. FUNERAL DIRECTOR
Nalley's Funeral Home Inc. | | 25a. REC'D BY REGISTRAR
DATE 15 1967 | |
| ADDRESS
Mt. Rainier, Maryland | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | |

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STATE OF TEXAS

STATE OF TEXAS

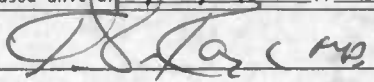
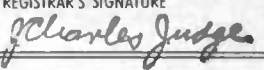
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06351

06341

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Essex (21) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Essex (21) | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
2262 Monocacy Rd. | | d. STREET ADDRESS
2262 Monocacy Rd. | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
GEORGE W. MANNER | | 4. DATE OF DEATH
Month Day Year
May 26, 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Aug. 5, 1901 |
| 9. AGE (In years lost birthday)
65 yrs. | | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Shipping Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY
Oil Co. | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Md. |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Agusta Manner | |
| 14. MOTHER'S MAIDEN NAME
Caroline Morecraft | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | |
| 16. SOCIAL SECURITY NO.
215 03 9093 | | 17. INFORMANT Address
Thelma Manner 2262 Monocacy Rd. Balto. 21 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction, fatal
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) Hypertensive arteriosclerotic C.V.D., dur. 5yr. +
DUE TO
(c) Generalized arteriosclerosis, moderate, advanced, 5yrs. + | | | INTERVAL BETWEEN ONSET AND DEATH
sudden |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
no | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (the physician) attended the deceased from 7/18/63 , 19__, to 5/26/67 , 19__, that (I) (we) saw the deceased alive on 5/24/67 , 19__, and that death occurred at 1 a.m. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
 | | 22b. DATE SIGNED
5/26/67 | |
| 22c. PHYSICIAN'S NAME (Type)
R.V. Rangle, M.D. | | 22d. ADDRESS
2938 St. Paul St., Baltimore, Md. 18 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
5/29/67 | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | 23d. LOCATION (City or Town) (County) (State)
Baltimore Co., Md. |
| 24. FUNERAL DIRECTOR
Bruzdzinski Funeral Home 1407 Eastern Ave. | | 25a. REC'D BY REGISTRAR
DATE MAY 29 1967 | 25b. REGISTRAR'S SIGNATURE
 |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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• *Productivity*

Jim

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CERTIFICATE OF DEATH

Reg. Dist. No. 06342

06352

| | | | |
|---|------------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore County</u>
<u>2203 Rockwell Rd.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD.</u>
b. COUNTY _____ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonsville 28</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> 31-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS
<u>3318 Fair Ave.</u>
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>ANNA</u> Middle _____ Last <u>MARTIN</u> | | 4. DATE OF DEATH
Month <u>May</u> Day <u>2</u> Year <u>1967</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>6-1889</u> |
| 9. AGE (In years last birthday) <u>77</u> yrs. | | 10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
<u>Lith.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>George Sprainis</u> | | 14. MOTHER'S MAIDEN NAME
<u>Elizabeth Serechkes</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____
If yes, give war or dates of service: _____ | | 16. SOCIAL SECURITY NO. _____
INFORMANT <u>Mr. Andrew Sprainis</u> Address <u>2203 Rockwell Rd.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic C.V. disease</u>
DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Semility</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 hour</u>
<u>?</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from <u>4/26</u> , 19 <u>67</u> , to <u>5/2</u> , 19 <u>67</u> , that I last saw the deceased alive on <u>5/1</u> , 19 <u>67</u> , and that death occurred at <u>7:15 A.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>A.C. Mac Laughlin</u> | | ADDRESS (Street, city or town, state) <u>303 N. Rolling Rd.</u> | |
| PHYSICIAN'S NAME (Type) _____ | | DATE SIGNED <u>5/2/67</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>5-5-67</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Parkwood</u> | 22d. LOCATION (City, town, or county) <u>MD.</u> (State) _____ |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Thelma R. Hoffman</u> | | ADDRESS <u>3218 Sudasth</u> | |
| 24a. REC'D BY REGISTRAR
DATE <u>MAY 8 1967</u> | | 24b. REGISTRAR'S SIGNATURE
<u>J. Charles J. J.</u> | |

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be notified. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06353

06343

| | | | | | |
|---|--|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE
MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY BALTIMORE | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. LENGTH OF STAY IN b
3 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
606 Stone Barn Road | | | d. STREET ADDRESS
606 Stone Barn Road | | |
| 3. NAME OF DECEASED
(Type or print)
EDWARD LAWRENCE MC CLOSKEY | | | 4. DATE OF DEATH
Month May Day 25 Year 19 67 | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Aug. 31, 1929 | | 9. AGE (In years last birthday)
37 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Financial Analyst | | 10b. KIND OF BUSINESS OR INDUSTRY
Westinghouse Elec. | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | |
| 13. FATHER'S NAME
Lawrence McCloskey | | | 14. MOTHER'S MAIDEN NAME
Edna Folger | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs. Anne McCloskey same as 2-d | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c) | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
Charles S. Springate | | M.D.
Charles S. Springate, M.D. | | 22. DATE SIGNED
May 25, 1967 | |
| EXAMINER'S NAME (Type) | | Address (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
May 27, 1967 | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Woodlawn, Maryland | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson 1050 York Road Towson, Maryland 21204 | | | 25a. REC'D BY REGISTRAR
MAY 29 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06354

CERTIFICATE OF DEATH

06344

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>BALTO</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CARNEY</u> | | c. LENGTH OF STAY IN 1b
<u>23 years</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CARNEY</u> <u>03-1</u> | | d. STREET ADDRESS
<u>9210 1/2 Hartford Rd</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>9210 1/2 Hartford Rd</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>CARROLL</u> Middle <u>N.</u> Last <u>McCreedy</u> | | 4. DATE OF DEATH
Month <u>MAY</u> Day <u>12</u> Year <u>1967</u> | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Oct 21-1903</u> |
| 9. AGE (In years last birthday)
<u>63</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life (even if retired))
<u>Printer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Letter Press</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>BALTO. MD</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>NORMAN McCreedy</u> | | 14. MOTHER'S MAIDEN NAME
<u>ANN CARROLL</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>212-09-0463</u> | |
| 17. INFORMANT
<u>Annabelle Callis</u> | | Address
<u>Same</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic carcinoma generalized</u>
1538 DUE TO
(b) <u>Carcinoma of colon</u>
DUE TO
(c) <u> </u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 yr</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u> </u> a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (1) (this hospital) attended the deceased from <u>7/10/66</u> , 19 <u>66</u> to <u>5/9</u> , 19 <u>67</u> that (1) (we) last saw the deceased alive on <u>5/9</u> , 19 <u>67</u> , and that death occurred at <u>5:30</u> a.m., from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Robert E. Martin</u> | | 22b. DATE SIGNED
<u>5/12/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>ROBERT E. MARTIN</u> | | 22d. ADDRESS
<u>3201 N. Charles ST</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 23b. DATE THEREOF
<u>5-15-67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Bel Air Memorial Garden</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Bel Air MD</u> |
| 24. FUNERAL DIRECTOR
<u>C. F. EVANS & SON</u> | | 25a. REC'D BY REGISTRAR
<u>MAY 16 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>J. Charles Judge</u> | | 25c. REGISTRAR'S SIGNATURE
<u>J. Charles Judge</u> | |

10334

STATEMENT OF DEBIT

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(10334)

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MAY 11 1984

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06355

CERTIFICATE OF DEATH

06345

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>G.B.M.C.</u> | | d. STREET ADDRESS <u>418 DONEGAL DRIVE</u>
<u>PATIENTS ADDRESS</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>EDNA</u> First Middle Last <u>MYRTLE McDONNELL</u> | | 4. DATE OF DEATH <u>5-2-67</u> Month Day Year <u>19 67</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-28 96</u> 9. AGE (In years lost birthday) <u>70</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>BALTO, MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>CALEB BOND</u> | | 14. MOTHER'S MAIDEN NAME <u>LENA Taylor</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>2-15-48-1841</u> | |
| 17. INFORMANT <u>M. RICHARD McDONNELL</u> Address <u>418 DONEGAL DR.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory arrest</u>
<u>331X</u> DUE TO (b) <u>cerebrovascular accident with</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u>probable intracerebral hemorrhage</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5-2</u> , 19 <u>67</u> , to <u>5-2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-2</u> 19 <u>67</u> , and that death occurred at <u>3:15</u> AM, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>V.R. BATOYON</u> | | 22b. DATE SIGNED <u>5-2-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>V. R. BATOYON</u> | | 22d. ADDRESS <u>6701 N. Charles ST. Balto, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>5-2-67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u> | 23d. LOCATION (City or Town) (County) (State) <u>Parkville Md.</u> |
| 24. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u> ADDRESS <u>4905 York Rd., Balto.</u> | | 25a. REC'D BY REGISTRAR <u>MAY 3 1967</u> | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> |

00382

DEPARTMENT OF DEFENSE

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Ordinance for acquisition with
probable international dimensions
to the

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06356

06346

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|---|----------------------------------|---|------------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY
BALTIMORE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
LOCH RAVEN RESEVOIR | | c. LENGTH OF STAY IN 1b
Hour
Hour | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
About one-half mile from bridge | | | | d. STREET ADDRESS
1 New Forrest Court | |
| 3. NAME OF DECEASED
(Type or print)
OLLIE SUE McIllyar | | 4. DATE OF DEATH
Month
5
Day
8
Year
19 67 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9-18-2D | 9. AGE (In years lost birthday)
45 yrs. | 10. IF UNDER 1 YEAR
Months
19
Days
67
Hours
Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Dallas, Texas | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Maithias Armstrong | | 14. MOTHER'S MAIDEN NAME
Eula Raines | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
415-26-5743 | | 17. INFORMANT
Mr. James D. McIllyar Address
1 New Forest Ct. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Drowning
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) 975X
DUE TO
(c) | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Drove car through gaurd rail and plunged into resevoir | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 3:57 p.m. 5 8 1967 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Reservoir | |
| 20f. (City or town)
Baltimore | | 20g. (County)
Md. | | 20h. (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
Werner U. Spitz | | EXAMINER'S NAME (Type)
WERNER U. SPITZ, M.D. | | 22. DATE SIGNED
5-9-67 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE THEREOF
5/11/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenmount Crematory | |
| 23d. LOCATION (City or Town)
Baltimore, Maryland | | 23e. REC'D BY REGISTRAR
MAY 10 1967 | | 23f. REGISTRAR'S SIGNATURE
Charles Judge | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson 1050 York Rd. 21204 | | | | | |

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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| | | | | | | | |
|---|----------------------------------|---|---|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Texas | | | | c. LENGTH OF STAY IN 1b
Years | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Church Lane | | | | d. STREET ADDRESS
Church Lane | | | |
| 3. NAME OF DECEASED
(Type or print)
Roy Dean McMillan | | | | 4. DATE OF DEATH
Month May Day 7 Year 19 67 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 4, 1917 | | 9. AGE (In years lost birthday)
50 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
North Carolina | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Grover McMillan | | | | 14. MOTHER'S MAIDEN NAME
Cora Moxley | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs. Mary Edith McMillan Church Lane, Texas | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4201
IMMEDIATE CAUSE (a) Coronary Occlusion Sudden
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Charles F. O'Donnell
EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D. | | | | 22. DATE SIGNED
5/7/67 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/11/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Jessops Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Sparks, Md. | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson 1050 York Rd. 21204 | | | | 25a. REC'D BY REGISTRAR
MAY 10 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

03351

03351

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06358

CERTIFICATE OF DEATH

06348

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 21206 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Josephs Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) Margaret E. MEEHAN | | 4. DATE OF DEATH
Month May Day 30 Year 19 67 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
December 8 1893 |
| 9. AGE (In years last birthday) 73 yrs. | | 10. BIRTHPLACE (County & State, or foreign country)
Maryland | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Dieter | | 14. MOTHER'S MAIDEN NAME
Mary Streb | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
220-05-0814 | |
| 17. INFORMANT
Mr. Milliam Meehan | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4500 General Arteriosclerosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May 30, 19 67 , to May 30, 19 67 , that (I) (we) last saw the deceased alive on May 30, 19 67 , and that death occurred at 1a M, from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
Ismael O. Jamora M.D. | | 22b. DATE SIGNED
May 30, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Ismael O. Jamora M.D. | | 22d. ADDRESS
7620 York Rd. Towson 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
June 2, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck Inc. 5305 Harford Rd. | | 25a. REC'D BY REGISTRAR
DATE MAY 31 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

00330

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 11-14-01 BY 60322 UCBAW/STP

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06359

CERTIFICATE OF DEATH

06349

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson (rural) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore -21236 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | d. STREET ADDRESS
2 Henry Avenue | |
| 3. NAME OF DECEASED (Type or print)
First Barbara Middle J. Last Meise | | 4. DATE OF DEATH
Month May Day 1 Year 1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5-15-01 |
| 9. AGE (In years last birthday)
65 yrs. | | IF UNDER 1 YEAR
Months 1 Days 1 Hours 1 Min. 1 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY
Bush Co. | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
Baltimore, Md. | |
| 13. FATHER'S NAME
Charles Mohr | | 14. MOTHER'S MAIDEN NAME
Elizabeth Kern | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
212-32-7314 | |
| 17. INFORMANT
Mr Kenneth Meise | | Address
2934 Edgewood Road #34 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ventricular fibrillation
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease
DUE TO
(c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that A (this hospital) attended the deceased from April 2, 1967 , to May 1, 1967 , that A (we) lost saw the deceased alive on May 1, 1967 , and that death occurred at 2:15AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
M.S. Cockburn | | 22b. DATE SIGNED
May 1, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
M.S. Cockburn, M.D. | | 22d. ADDRESS
7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
5-4-1967 | 23c. NAME OF CEMETERY OR CREMATORY
St. Peters Cemetery | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Co. Md. |
| 24. FUNERAL DIRECTOR
Larsen Funeral Home 7401 Belair Road | | 25a. REC'D BY REGISTRAR
MAY 3 1967 | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE
c. LENGTH OF STAY IN 1b 8-30-67
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOS | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE MD b. COUNTY P.B.C.P.
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ADELPHI MD
d. STREET ADDRESS 2004, GRIFFIN ST
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) RUBIN First Middle Last
4. DATE OF DEATH MAY 7 1967 Month Day Year | | 5. SEX M 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 8-21-85 9. AGE (In years last birthday) 81 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR 10b. KIND OF BUSINESS OR INDUSTRY CLOTHING 11. BIRTHPLACE (County & State, or foreign country) RUSSIA 12. CITIZEN OF WHAT COUNTRY? RUSSIA | | 13. FATHER'S NAME ERIC MENDELSON 14. MOTHER'S MAIDEN NAME HANNAH MENDELSON | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO 16. SOCIAL SECURITY NO. 497-36-8462 17. INFORMANT SPRING GROVE STATE HOS Address | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4341
(b) Pneumonia
(c) DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 8-30- , 19 62 , to 5-7- , 19 67 , that (I) (we) last saw the deceased alive on 5-7 , 19 67 , and that death occurred at 2:00 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Ricardo Ibanez 22b. DATE SIGNED 5-7-67
M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. PHYSICIAN'S NAME (Type) RICARDO IBANEZ 22d. ADDRESS Spring Grove Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 5/9/1967 23c. NAME OF CEMETERY OR CREMATORY GEO. WASH. Cem. 23d. LOCATION (City, town or county) (State) HYATTSVILLE, MD | | 24. FUNERAL DIRECTOR Charles Judge ADDRESS 4217 9th St. NW 25a. REC'D BY REGISTRAR MAY 9 1967 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06361

CERTIFICATE OF DEATH

06351

| | | | |
|---|----------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | c. LENGTH OF STAY IN 1b
24 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | d. STREET ADDRESS
3614 LYNDALE AVENUE | |
| 3. NAME OF DECEASED
(Type or print)
First GEORGE Middle CHARLES Last MENZEL | | 4. DATE OF DEATH
Month MAY Day 20 Year 1967 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4/5/10 |
| 9. AGE (In years last birthday)
57 yrs. | | 10. UNDER 1 YEAR
Months Days Hours Min. | 11. UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
BOOK BINDING | | 10b. KIND OF BUSINESS OR INDUSTRY
BUREAU OF ENGRAVING | |
| 11. BIRTHPLACE (County & State, or foreign country)
BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
GEORGE A. MENZEL | | 14. MOTHER'S MAIDEN NAME
FLORENCE WENZEL | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) YES WWII | | 16. SOCIAL SECURITY NO.
214 01 41 57 | |
| 17. INFORMANT
CLINICAL RECORDS, VAH, FT. HOWARD, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA, LEFT SIDE, WITH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) METASTASES
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
Unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Nat While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/26 , 19 67 , to 5/20 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 5/20/67 19 67 , and that death occurred at 3:45M , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Paulino D. Deocampo | | P. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE SIGNED 5/21/67 | |
| 22c. PHYSICIAN'S NAME (Type)
PAULINO D. DEOCAMPO, M.D. | | 22d. ADDRESS
VA Hospital, Fort Howard, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/24/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
Schimunek Funeral Home | | 25a. REC'D BY REGISTRAR
MAY 23 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06362

CERTIFICATE OF DEATH

06352

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|---|----------------------------------|---|------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH
o. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE Maryland b. COUNTY 304 | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | c. LENGTH OF STAY IN lb
2 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Veterans Administration Hospital | | | | d. STREET ADDRESS
900 Cathedral Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
MORRIS ----- MICHAEL | | | | 4. DATE OF DEATH Month Day Year
May 11 1967 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9/26/94 | | 9. AGE (In years lost birthday) yrs.
72 | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY
Clothing Industry | | 11. BIRTHPLACE (County & State, or foreign country)
Hudson, New York | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Jacob Michael | | | | 14. MOTHER'S MAIDEN NAME
Sarah Litsitz | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WW-1 | | 16. SOCIAL SECURITY NO.
215 01 56 30 | | 17. INFORMANT Address
Clinical Rcds. VA Hospital, Fort Howard, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY EDEMA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) METASTATIC ADENOCARCINOMA LUNGS, LIVER, ADRENALS AND RIBS
(c) ARTERIOSCLEROSIS, GENERALIZED | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Recent | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
SURGICAL ABSENCE RIGHT COLON (ADENOCARCINOMA) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that 4 (this hospital) attended the deceased from May 9 , 19 67 , to May 11 , 19 67 that 4 (we) last saw the deceased alive on May 11 , 19 67 , and that death occurred at 12:20 PM from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Milton Ginsberg | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
5/12/67 | |
| 22c. PHYSICIAN'S NAME (Type)
MILTON GINSBERG, M.D. | | | | 22d. ADDRESS
VA Hospital, Fort Howard, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/15/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
ZANNINO FUNERAL HOME | | ADDRESS
237 S. Conking St. Balto. Md. | | 25a. REGD. BY REGISTRAR
MAY 15 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
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| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 23 days | | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE Maryland
b. COUNTY Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit Rural | | | | d. STREET ADDRESS None
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Mattie Blanche Mitchell
First Middle Last | | | | 4. DATE OF DEATH May 12 1967
Month Day Year | | | | 5. SEX Female
6. COLOR OR RACE White
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 8. DATE OF BIRTH 5-28-74
9. AGE (In years last birthday) 92 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife Ret. Own Home
10b. KIND OF BUSINESS OR INDUSTRY None | | | | 11. BIRTHPLACE (County & State, or foreign country) West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME Marion Summer
14. MOTHER'S MAIDEN NAME Amy Ellen Haley | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
16. SOCIAL SECURITY NO. 220-18-7751
17. INFORMANT Records Spring Grove State Hospital
Address | | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardio vascular Disease
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hip fracture (left) and generalized arteriosclerosis | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | 20c. TIME OF INJURY Month, Day, Year 19
Hour a.m. p.m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) Spring Grove State Hospital
(County) Baltimore
(State) Md. | | | | 21. I certify that (this hospital) attended the deceased from 4-17-67 , 19 67 , to May 12 , 19 67 , that (we) last saw the deceased alive on May 12 , 19 67 , and that death occurred at 4:05 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Anthony J. Young, M.D.
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D. | | | | 22b. DATE SIGNED 5-12-67
22d. ADDRESS Spring Grove State Hospital
Baltimore, Maryland 21228 | | | | 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 5-15-1967
23c. NAME OF CEMETERY OR CREMATORY Brookview Cem.
23d. LOCATION (City, town or county) Rising Sun
(State) Md. | | | |
| 24. FUNERAL DIRECTOR Richard L. Goodie
25a. REC'D BY REGISTRAR Charles Judge
25b. REGISTRAR'S SIGNATURE Charles Judge | | | | DATE MAY 16 1967 | | | | | | | |

003558

003558

Estimated 25 days
Fort Deposit

Home
Miscellaneous
Lumber

200-10-1000
200-10-1000

200-10-1000
200-10-1000

200-10-1000
200-10-1000

200-10-1000
200-10-1000

200-10-1000
200-10-1000

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06364

CERTIFICATE OF DEATH

06354

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> | | c. LENGTH OF STAY IN lb
<u>131</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>3711 Washington Ave</u> | | d. STREET ADDRESS
<u>3711 Washington Ave</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>John</u> Middle <u>Randolph</u> Last <u>Moore</u> | | 4. DATE OF DEATH
Month <u>MAY</u> Day <u>16</u> Year <u>1967</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>11-19-1902</u> |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>ACCOUNTANT</u> | | 9b. KIND OF BUSINESS OR INDUSTRY
<u>Baltimore</u> | 9c. AGE (In years last birthday)
<u>64</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>ACCOUNTANT</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Baltimore</u> | 10c. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Baltimore</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Charles T. Moore</u> | | 14. MOTHER'S MAIDEN NAME
<u>De Lacy</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>212-03-6028</u> | |
| 17. INFORMANT
<u>Jeanette F. Moore - Same.</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4300 ARTERIOSCLEROTIC HEART DISEASE</u>
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH
<u>20 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>HEMIPLEGIA, RIGHT DUE TO OLD CVA</u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>19</u> o.m. p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>JULY, 1957</u> to <u>MAY 16, 1967</u> , that (I) (we) last saw the deceased alive on <u>MAY 14, 1967</u> , and that death occurred at <u>10 P.</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Marvin Goldstein</u> | | 22b. DATE SIGNED
<u>5/18/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>MARVIN GOLDSTEIN</u> | | 22d. ADDRESS
<u>6001 PARK HEIGHTS AVE. 21215</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 23b. DATE THEREOF
<u>5-19-67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Woodlawn Cem</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Md</u> |
| 24. FUNERAL DIRECTOR
<u>ELLSWORTH ARMACOST</u> | | 25a. REC'D BY REGISTRAR
<u>Charles Judge</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | DATE <u>MAY 22 1967</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00354

CERTIFICATE OF DEATH

00354

ARTERIO-SCLEROTIC HEART DISEASE 30 YRS.

HEMIPLEGIA, RIGHT DUE TO OLD CVA

MAY 10 1967

10-1-67

MAY 11 1967

MARVIN GOLDSTEIN / 1001 PARK AVENUE

THE NEW YORK PUBLIC LIBRARY
ASTOR LENOX TILDEN FOUNDATIONS
1001 PARK AVENUE
NEW YORK, N.Y. 10022

00333

CERTIFICATE OF DEATH

00333

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of registrar: [illegible]
9. Signature of informant: [illegible]
10. Date of registration: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06366

CERTIFICATE OF DEATH

06356

| | | | | | | | |
|---|---|---|--|--|--|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | | c. LENGTH OF STAY in 1b
53 DAYS | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | | | d. STREET ADDRESS
7201 Belair Rd | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First WILLIAM Middle HENRY Last MORRIS | | | | 4. DATE OF DEATH
Month MAY Day 26 Year 19 67 | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
MAY 21, 1894 | | 9. AGE (In years last birthday) yrs.
73 | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CHAUFFEUR | | 10b. KIND OF BUSINESS OR INDUSTRY
TAXICAB | | 11. BIRTHPLACE (County & State, or foreign country)
BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
HARRY MORRIS | | | | 14. MOTHER'S MAIDEN NAME
BARBARA SACHS | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW I | | 16. SOCIAL SECURITY NO.
217 03 43 39 | | 17. INFORMANT Address
CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) COR PULMONALE
5020 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC BRONCHITIS AND PULMONARY EMPHYSEMA DUE TO
(c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
UNKNOWN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
ARTERIOSCLEROTIC HEART DISEASE | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) this hospital attended the deceased from 4/3/67 , 19__, to 5/26/67 , 19__, that (X) (we) last saw the deceased alive on 5/26/67 , 19__, and that death occurred at 5:45AM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>Peter V. Juvan</i> | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
5/26/67 | |
| 22c. PHYSICIAN'S NAME (Type)
PETER V. JUVAN, M. D. | | | | 22d. ADDRESS
VAH FORT HOWARD, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
5/29/67 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR
<i>Joseph N. Zannino</i> | | | | ADDRESS
ZANNINO FUNERAL HOME | | 25a. REC'D BY REGISTRAR | |
| 257 S. CONKLING ST. BALTIMORE, MD. | | | | DATE MAY 28 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF TEXAS

00350

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WITNESSES

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06367

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06357

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTO</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>BALTO</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CATONSVILLE</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CATONSVILLE</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>41 BLOOMSBURY AVE</u> | | d. STREET ADDRESS
<u>41 BLOOMSBURY AVE</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>FRANCES E. MORSBERGER</u> | | 4. DATE OF DEATH
Month <u>5</u> Day <u>28</u> Year <u>1967</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>2/7/97</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>NONE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday)
<u>70</u> yrs. |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Edw. Wm. MORSBERGER</u> | | 14. MOTHER'S MAIDEN NAME
<u>MARY J. ESPEY</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT
<u>EDITH T. MORSBERGER</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>
4221 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Arteriosclerotic Cardiovascular Disease</u>
DUE TO
(c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 mo</u>
<u>10 30</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>a.m.</u> <u>19</u> p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>48</u> to <u>May 27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 28</u> , 19 <u>67</u> , and that death occurred at <u>6:30</u> A.M., from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Wilmer K. Gallagher, M.D.</u> | | 22b. DATE SIGNED
<u>May 29, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Wilmer K. Gallagher, Sr. M.D.</u> | | 22d. ADDRESS
<u>6209 Frederick Ave. Baltimore 28 Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 23b. DATE THEREOF
<u>5/29/67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>LOUDON PARK</u> | 23d. LOCATION (City or Town) (County) (State)
<u>BALTO. MD.</u> |
| 24. FUNERAL DIRECTOR
<u>E.S. MACIVABB</u> | | 25. REC'D BY REGISTRAR
<u>MAI 31 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

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CONTRACT NO. 1000

1000



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06368

CERTIFICATE OF DEATH

06358

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|---------------------------------|---|--|--|--------------------------------------|--|----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE | | | | c. LENGTH OF STAY IN it | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Greater Balto. Medical Center | | | | d. STREET ADDRESS
1512 Riderwood Lutherville | | | |
| 3. NAME OF DECEASED (Type or print)
Clarence Charles Nash | | | | 4. DATE OF DEATH
Month 5 Day 15 Year 1967 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
CAU. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/20/12 | 9. AGE (In years last birthday)
54 yrs. | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Fire Chief | | 10b. KIND OF BUSINESS OR INDUSTRY
BALTO. COUNTY | | 11. BIRTHPLACE (County & State, or foreign country)
Balto. md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Charles Leroy Nash | | | | 14. MOTHER'S MAIDEN NAME
DORA. T. Sheeler | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
UN KNOWN | | 16. SOCIAL SECURITY NO.
218-05-0895 | | 17. INFORMANT Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4221 Atherosclerotic cardiovascular disease
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Sleus and early peritonitis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from March , 19 67 , to 5/15 , 19 67 , that (I) (we) last saw the deceased alive on 5/15 , 19 67 , and that death occurred at 6:30 P.M. , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Derek A Bruce | | | | 22b. DATE SIGNED
5/16/67 | | 22c. PHYSICIAN'S NAME (Type)
DEREK A BRUCE | |
| 22d. ADDRESS
G.D.M.C. | | | | 22e. REC'D BY REGISTRAR
MAY 22 1967 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
5-18-67 | | 23c. NAME OF CEMETERY OR CREMATORY
POPLAR GROVE CEM. | | 23d. LOCATION (City or Town) (County) (State)
COCKEYSVILLE MD. | |
| 24. FUNERAL DIRECTOR
John Burns Son's | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

00358

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00358



1. The first part of the document is a letter from the
2. The second part is a letter from the
3. The third part is a letter from the
4. The fourth part is a letter from the
5. The fifth part is a letter from the
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IX



1. The first part of the document is a letter from the
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1. The first part of the document is a letter from the
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10. The tenth part is a letter from the

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06363

06359

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Towson

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Bendix Radio, Joppa Rd.

2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)

a. STATE

Md.

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Baltimore

d. STREET ADDRESS

4591 St. Georges Ave.

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)

ROBERT

BRUCE

NEELY

4. DATE OF DEATH

Month

Day

Year

May

11

1967

5. SEX

Male

6. COLOR OR RACE

C

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

9/12/09

9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.

57 yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Porter

10b. KIND OF BUSINESS OR INDUSTRY

Communications

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Weeler Neely

14. MOTHER'S MAIDEN NAME

Millie Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

Yes

WW II

16. SOCIAL SECURITY NO.

110 10 1942

17. INFORMANT

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Myocardial Infarction

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Arteriosclerotic Cardiovascular Disease

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

5 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.

19

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

William A. Pillsbury

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

May 11, 1967

EXAMINER'S NAME (Type)

William A. Pillsbury

Address (City, town, or county)

Timonium, Md.

22b. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

22c. DATE THEREOF

5/14/67

22d. NAME OF CEMETERY OR CREMATORY

St. Verron Presbyterian Rowan Co. N. Carolina

22e. LOCATION (City, town, or country)

(State)

23. FUNERAL DIRECTOR

Helyn St. Johnson 8521 Loch Raven Blvd.

24a. REC'D BY REGISTRAR

MAY 15 1967

24b. REGISTRAR'S SIGNATURE

Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00352

00352



1944-1945

London

British Railways, London E.C.4.

1901-1902, London E.C.4.

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Printed at the London Printing Works, 1, Finsbury Pavement, London E.C.2.
MAY 12 1901
1901-1902

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06370

06360

| | | | | | |
|---|-------------------------------------|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY
BALTIMORE
MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Arbutus | | c. LENGTH OF STAY IN 1b
Lifetime | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Arbutus | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
1118 Sulphur Spring Road 21227 | | | d. STREET ADDRESS
1118 Sulphur Spring Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
ELIZABETH ELLEN NICHOLS | | | 4. DATE OF DEATH
Month Day Year
May 20 19 67 | | |
| 5. SEX
Female | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan 25, 1912 | 9. AGE (In years lost birthday)
55 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Custodian | | 10b. KIND OF BUSINESS OR INDUSTRY
Telephone Co. | | 11. BIRTHPLACE (State or foreign country)
Arbutus, Maryland | |
| 13. FATHER'S NAME
Henson Garrett | | | 14. MOTHER'S MAIDEN NAME
Margaret Johnson | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
214-18-6456 | | 17. INFORMANT
Mrs. Vivian Schofield Address
5211 Addison Rd N.E. Washington, D.C. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease associated
4221
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) with diabetes mellitus
(c) _____
DUE TO | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
RUSSELL S. FISHER, M.D. | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22. DATE SIGNED
5-22-67 | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| | | Address (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
5/25/67 | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial Park | | 23d. LOCATION (City or Town) (County) (State)
Arbutus Balto Co Md | |
| 24. FUNERAL DIRECTOR
Herbert E. Nutter | | ADDRESS
3035 W. North Ave | | 25a. REC'D BY REGISTRAR
DATE MAY 23 1967 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | |

00330

00330

00330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06371

CERTIFICATE OF DEATH

06361

| | | | | | | | |
|---|----------------------------------|---|---|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | | c. LENGTH OF STAY IN TB
54 DAYS | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | | | d. STREET ADDRESS
2306 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
First Middle Last
CHARLES NMI NUTT | | | | 4. DATE OF DEATH
Month Day Year
MAY 28, 19 67 | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4/28/92 | | 9. AGE (In years last birthday)
75 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABORER | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
CALTO, VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
ARTHUR NUTT | | | | 14. MOTHER'S MAIDEN NAME
EMALINE LEYLAND | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WWI | | 16. SOCIAL SECURITY NO.
111 12 23 86 | | 17. INFORMANT
CLINICAL RECORDS, VAH, FT. HOWARD, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF STOMACH
DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
ARTERIOSCLEROTIC HEART DISEASE AND CHRONIC PYELONEPHRITIS | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 4/4/67 , 19 67 , to 5/28 , 19 67 that (I) (we) last saw the deceased alive on 19 , and that death occurred at 5 M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>John D. Talbert</i> | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
5-29-67 | |
| 22c. PHYSICIAN'S NAME (Type)
JOHN D. TALBERT, M. D. | | | | 22d. ADDRESS
VA HOSPITAL FORT HOWARD, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or town) (County) (State) | |
| Burial | | 5-1-67 | | Baltimore Md | | Baltimore Md | |
| 24. FUNERAL DIRECTOR
ELROY WILSON 1000 Brantley Ave. Balto. Md. | | | | 25a. REC'D BY REGISTRAR
DATE MAY 31 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Jones</i> | |

06330

06330

MARYLAND

BALTIMORE

BALTIMORE

Q DATE

PORT HOWARD

2630 AVAIAH AVENUE

VETERANS ADMINISTRATION HOSPITAL

67

28

MAY

WUTI

NOI

CHARLES

75

W/28/25

1

HEXSO

WALE

U.S.A.

CAIRO, VIRGINIA

JABORER

RMALINE INYLAND

ARTHUR WUTI

YES 111 IS 23 86 ORIGINAL RECORD, VAR, PT. HOWARD, MD.

WMI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

10

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06372

CERTIFICATE OF DEATH

06352

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore Highlands | | c. LENGTH OF STAY IN 1b
3 Mos. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
4048 Mc Dowell Lane | | e. STREET ADDRESS
4107 Oak Rd. | |
| 3. NAME OF DECEASED
(Type or print) Thomas W. O'Brien | | 4. DATE OF DEATH
Month May Day 11 Year 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
August 19, 1897 |
| 9. AGE (In years lost birthday) 69 yrs. | | 10. IF UNDER 1 YEAR
Months 11 Days 19 Hours 67 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Cable Splicer (Ret) | | 10b. KIND OF BUSINESS OR INDUSTRY
Balto. Gas & Elec. Frederick, Md. | |
| 11. BIRTHPLACE (County & State, or foreign country)
USA | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
O'Brien | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) None | | 16. SOCIAL SECURITY NO.
212-05-5967 | |
| 17. INFORMANT
Mrs. Jane C. Denney (daughter) | | Address 307 Penna. Ave Elkton, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatous
DUE TO Primary C.A. of Lung.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Nov 11 , 19 64 to 5/11 , 19 67 , that (II) (we) last saw the deceased alive on 5/11 , 19 67 , and that death occurred at 1:45 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
E.M. RAMOS M.D. | | 22b. DATE SIGNED
5/12/67 | |
| 22c. PHYSICIAN'S NAME (Type)
E.M. RAMOS M.D. | | 22d. ADDRESS
3927 Annapolis Rd Balt 27 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
May 13, 1967 | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | 23d. LOCATION (City or Town) (County) (State)
Brooklyn RD Maryland Md |
| 24. FUNERAL DIRECTOR
Richard V. Singleton Glen Burnie, Md. | | 25. REC'D BY REGISTRAR
Charles Judge | |
| 25a. DATE
MAY 15 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

00332

CHINESE NEW YEAR

00332

1. Name: Mr. [illegible]
 2. Address: [illegible]
 3. Date: [illegible]
 4. [illegible]
 5. [illegible]
 6. [illegible]
 7. [illegible]
 8. [illegible]
 9. [illegible]
 10. [illegible]

11. [illegible]
 12. [illegible]
 13. [illegible]
 14. [illegible]
 15. [illegible]
 16. [illegible]
 17. [illegible]
 18. [illegible]
 19. [illegible]
 20. [illegible]
 21. [illegible]
 22. [illegible]
 23. [illegible]
 24. [illegible]
 25. [illegible]
 26. [illegible]
 27. [illegible]
 28. [illegible]
 29. [illegible]
 30. [illegible]



31. [illegible]
 32. [illegible]
 33. [illegible]
 34. [illegible]
 35. [illegible]
 36. [illegible]
 37. [illegible]
 38. [illegible]
 39. [illegible]
 40. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06373

CERTIFICATE OF DEATH

06363

| | | | | | | | |
|--|--|---|-------------------------|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY BALTIMORE | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 21234 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | | | d. STREET ADDRESS
3003 Lavender Ave. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Orrie Middle Wilkens Last Oldland | | | | 4. DATE OF DEATH May 31 19 67 | | | |
| 5. SEX
male | | 6. COLOR OR RACE
white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Aug. 23 1898 | |
| 9. AGE (In years last birthday) yrs.
68 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
Coal Mine | | 11. BIRTHPLACE (County & State, or foreign country)
Penna. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 13. FATHER'S NAME
Walter Oldland | | | |
| 14. MOTHER'S MAIDEN NAME
Ella ? | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT Address
Mrs Rose Oldland 3003 Lavender Avenue | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May 30 , 19 67 , to May 31 , 19 67 , that (I) (we) last saw the deceased alive on May 31 , 19 67 , and that death occurred at 5:35 PM from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Nelson S. de la Paz | | | | 22b. DATE SIGNED
May 31 1967 | | 22c. PHYSICIAN'S NAME (Type)
Nelson S. de la Paz | |
| 22d. ADDRESS
7620 York Rd. Baltimore, Md. 21204 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
6-3-1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Laurel Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Uniontown, Penna. | |
| 24. FUNERAL DIRECTOR
Lassahn Funeral Home 2401 Belair Road | | | | 25a. REC'D BY REGISTRAR
JUN 5 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

42830

65620

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06374

CERTIFICATE OF DEATH

06364

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
6mth7days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Spring Grove State Hospital | | e. STREET ADDRESS
3023 Second Avenue | |
| 3. NAME OF DECEASED (Type or print)
First Emma Middle Frances Last O'Mara | | 4. DATE OF DEATH
Month May Day 24 Year 1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 14, 1889 |
| 9. AGE (In years last birthday)
78 yrs. | | 10. IF UNDER 1 YEAR
Months 78 Days 13 Hours 1 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
House Wife | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Edmund Bry 44 | | 14. MOTHER'S MAIDEN NAME
Anna Ambrose | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
212-03-0945 | |
| 17. INFORMANT
Records: Spring Grove State Hospital | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Suppurative bronchopneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) 491X
(c) Decubitus ulcer | | INTERVAL BETWEEN ONSET AND DEATH
3 weeks | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)
Decubitus ulcer | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that 44 (this hospital) attended the deceased from 11-17-66 , 19 66 , to May 24 , 19 67 , that 44 (we) last saw the deceased alive on 19 , and that death occurred at 19 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Anthony J. Young, M.D. | | 22b. DATE SIGNED
5-24-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Anthony J. Young, M.D. | | 22d. ADDRESS
Spring Grove State Hospital
Baltimore, Maryland 21228 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
5-27-1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer | | 23d. LOCATION (City or town) (County) (State)
BALTO Md | |
| 24. FUNERAL DIRECTOR
C.F. EVANS & Son | | 25a. REC'D BY REGISTRAR
8802 HAROLD Rd | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | DATE MAY 29 1967 | |

03334

03334

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535

TO : DIRECTOR, FBI (100-371000)

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

100-371000-1000

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

20
15-1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

58

2

1

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06375

06365

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. LENGTH OF STAY IN 1b
13-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | d. STREET ADDRESS
8415 Hallmark Circle | |
| 3. NAME OF DECEASED (Type or print)
First Teresa Middle A. Last Panico | | 4. DATE OF DEATH
Month May Day 14 Year 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4-16-89 |
| 9. AGE (In years last birthday)
78 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME
Guy Gamberdell | | 14. MOTHER'S MAIDEN NAME
Laurana (Maurig) Maurio | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
220449470 | |
| 17. INFORMANT
Mr. Lawrence J. Panico | | Address
1806 Willann Rd. #6 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Atelectasis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Chronic Pulmonary Disease
DUE TO
(c) Congestive Heart Failure 'secondary to A.S.C.V.D. | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May 14 , 19 67 , to May 14 , 19 67 that (I) (we) last saw the deceased alive on May 14 , 19 67 , and that death occurred at 6:30 PM from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Ramon P. Lopez | | 22b. DATE SIGNED
5-14-67 | |
| 22c. PHYSICIAN'S NAME (Type) Ramon P. Lopez | | 22d. ADDRESS
7620 York Rd. Baltimore, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5-17-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Moreland Memorial Cem. | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 | | 25a. REC'D BY REGISTRAR
MAY 15 1967 | |
| 25b. REGISTRAR'S SIGNATURE
f Charles Judge | | | |

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CONTINUATION OF DATA

| | | | | | | | | | |
|---|--|---|--|--------------------------|--|--------------------------|--|---------------------------|--|
| 1. Name of the person or organization | | 2. Address | | 3. City | | 4. State | | 5. Zip | |
| 6. Date of birth or date of organization | | 7. Date of death or date of organization | | 8. Date of last contact | | 9. Date of last contact | | 10. Date of last contact | |
| 11. Name of the person or organization | | 12. Address | | 13. City | | 14. State | | 15. Zip | |
| 16. Date of birth or date of organization | | 17. Date of death or date of organization | | 18. Date of last contact | | 19. Date of last contact | | 20. Date of last contact | |
| 21. Name of the person or organization | | 22. Address | | 23. City | | 24. State | | 25. Zip | |
| 26. Date of birth or date of organization | | 27. Date of death or date of organization | | 28. Date of last contact | | 29. Date of last contact | | 30. Date of last contact | |
| 31. Name of the person or organization | | 32. Address | | 33. City | | 34. State | | 35. Zip | |
| 36. Date of birth or date of organization | | 37. Date of death or date of organization | | 38. Date of last contact | | 39. Date of last contact | | 40. Date of last contact | |
| 41. Name of the person or organization | | 42. Address | | 43. City | | 44. State | | 45. Zip | |
| 46. Date of birth or date of organization | | 47. Date of death or date of organization | | 48. Date of last contact | | 49. Date of last contact | | 50. Date of last contact | |
| 51. Name of the person or organization | | 52. Address | | 53. City | | 54. State | | 55. Zip | |
| 56. Date of birth or date of organization | | 57. Date of death or date of organization | | 58. Date of last contact | | 59. Date of last contact | | 60. Date of last contact | |
| 61. Name of the person or organization | | 62. Address | | 63. City | | 64. State | | 65. Zip | |
| 66. Date of birth or date of organization | | 67. Date of death or date of organization | | 68. Date of last contact | | 69. Date of last contact | | 70. Date of last contact | |
| 71. Name of the person or organization | | 72. Address | | 73. City | | 74. State | | 75. Zip | |
| 76. Date of birth or date of organization | | 77. Date of death or date of organization | | 78. Date of last contact | | 79. Date of last contact | | 80. Date of last contact | |
| 81. Name of the person or organization | | 82. Address | | 83. City | | 84. State | | 85. Zip | |
| 86. Date of birth or date of organization | | 87. Date of death or date of organization | | 88. Date of last contact | | 89. Date of last contact | | 90. Date of last contact | |
| 91. Name of the person or organization | | 92. Address | | 93. City | | 94. State | | 95. Zip | |
| 96. Date of birth or date of organization | | 97. Date of death or date of organization | | 98. Date of last contact | | 99. Date of last contact | | 100. Date of last contact | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~insert~~ ^{insert} carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06376

CERTIFICATE OF DEATH

06366

| | | | | | | | |
|--|----------------------------------|---|------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | | | c. LENGTH OF STAY IN 1b
2 Days | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lansdowne 03-1 | | | | d. STREET ADDRESS
701 Fifth Avenue | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Veterans Administration Hospital | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First JOHN Middle BENJAMIN Last PARKER | | | | 4. DATE OF DEATH
Month MAY Day 31 Year 1967 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9/28/19 | | 9. AGE (In years last birthday)
47 yrs. | 10. IF UNDER 1 YEAR
Months 4 Days 2 Hours 1 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mechanic | | 10b. KIND OF BUSINESS OR INDUSTRY
Fisher Auto Parts | | 11. BIRTHPLACE (County & State, or foreign country)
Benson, North Carolina | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Lester Parker | | | | 14. MOTHER'S MAIDEN NAME
Eleanora Beasley | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WW II | | 16. SOCIAL SECURITY NO.
217-03-85-37 | | 17. INFORMANT
Clinical Records, VAH, Fort Howard, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF ESOPHAGUS
150X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH
4-5 MONTHS | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from May 29 , 19 67 , to May 31 , 19 67 , that (X) (we) last saw the deceased alive on May 31 , 19 67 , and that death occurred at 4:00AM from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>George C. McElpatrick M.D.</i> | | | | 22b. DATE SIGNED
5/31/67 | | 22c. PHYSICIAN'S NAME (Type)
GEORGE C. MC ELPATRICK, M. D. | |
| 22d. ADDRESS
VA HOSPITAL, FORT HOWARD, MARYLAND | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
6/3/1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Louden Park Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
North & Pennsylvania
Wm. J. Tickner & Sons | | | | 25a. REC'D BY REGISTRAR
JUN 1 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

03366

CENTROCAT DE BATH

03376

Baltimore

Maryland

Baltimore

Landdowne

2 days

Fort Howard

701 Fifth Avenue

Veterans Administration Hospital

07

01

MAY

BARKER

BENJAMIN

JOHN

X

17

2/20/75

White

Male

U.S.A.

Bannon, North Carolina

Prater Auto Parts

Mechanics

Minerva Bousley

Dexter Parker

Yes, Fort Howard, Maryland

217-02-82-37

We II

Yes

MAY 31 07 x

MAY 29 07

MAY 31 07

x

2/27/67

VA HOSPITAL, FORT HOWARD, MARYLAND

Baltimore, Maryland

London Park Cemetery

Burial

North & Pennsylvania

Baltimore, Maryland

W.L. Tichenor & Sons

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|--|--|--|--|---|---|--|--|--|---|
| 06377 | | | | | 06367 | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY _____ | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Catonsville | | | c. LENGTH OF STAY IN 1b
4yr5mth18dys | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Baltimore | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | | | | d. STREET ADDRESS
419 North Pulaski Street | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) | | First Mary | | Middle Bessie | | Last Pearce | | 4. DATE OF DEATH
Month May Day 2 Year 1967 | |
| 5. SEX
female | | 6. COLOR OR RACE
white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Nov. 25, 1891 | | 9. AGE (In years last birthday)
75 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWORK | | 10b. KIND OF BUSINESS OR INDUSTRY
DOMESTIC | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | | |
| 13. FATHER'S NAME
Samuel Pearce | | | | 14. MOTHER'S MAIDEN NAME
Phoebe Christina Boyd | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | | Address _____ | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure
DUE TO (b) Bronchopneumonia
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Generalized arteriosclerosis | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that he (this hospital) attended the deceased from Nov. 14, 1962 to May 2, 1967 , that he (we) last saw the deceased alive on May 2, 1967 , and that death occurred at 8:30 M, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<i>Anthony J. Young</i> | | a. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
5-2-67 | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
Anthony J. Young, M.D. | | 22d. ADDRESS SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 21228 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
5-5-67 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood | | 23d. LOCATION (City, town or county) (State)
BALTO. County Md. | | | |
| 24. FUNERAL DIRECTOR
Geo. L. Schwab | | ADDRESS
Francis H. Miller 2101 Frederick Ave. | | 25a. REC'D BY REGISTRAR
MAY 4 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>William Judge</i> | | | |

MEDICAL CERTIFICATION

00337

00337

Noted

Noted

Noted

Noted

Noted

NOTED

Noted

Noted

Noted

Noted

Noted

Noted

Noted

Noted

Noted

Noted

Noted

Noted

Noted

Noted

Noted

Noted

Noted

Noted

Noted

Noted

Noted

Noted

Noted

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06378

06368

| | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Texas
c. LENGTH OF STAY in b years
03.1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
138 Church Lane | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Texas
d. STREET ADDRESS
138 Church Lane
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) DORA ELIZABETH PERRY
First Middle Last | | | | 4. DATE OF DEATH May 2, 1967
Month Day Year | | | | | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
May 21, 1880 | | 9. AGE (In years last birthday)
86 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Home | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
Joshua Green | | | | | | 14. MOTHER'S MAIDEN NAME
Mary Elizabeth Martin | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
218-54-2912J1 | | 17. INFORMANT Address
Mr. C. Lester Perry, Same as # 2 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thromboses MULTIPLE
332X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO
(c) | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
10 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (1) (this hospital) attended the deceased from Aug 21, 1965 to 4/27/67, that (1) (we) last saw the deceased alive on 4/29/67, and that death occurred at 11 AM from causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE
 | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
M.D. | | | | 22b. DATE SIGNED
5/3/67 | | | |
| 22c. PHYSICIAN'S NAME (Type)
Donald O. Wood, M. D. | | | | | | 22d. ADDRESS
York Rd. and Greenmeadow, Timonium, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
May 5, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Jessop Cemetery | | | | 23d. LOCATION (City or Town) (County) (State)
Sparks, Baltimore Co., Md. | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS
Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204 | | | | | | 25a. REC'D BY REGISTRAR
MAY 5 1967 | | 25b. REGISTRAR'S SIGNATURE
 | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06379

06369

| | | | | | | | |
|---|----------------------------------|---|--|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | c. LENGTH OF STAY IN 1b
7 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
3604 Tulsa Road | | | | d. STREET ADDRESS
3604 Tulsa Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Margaret Middle A. Last Pfeiffer | | | | 4. DATE OF DEATH
Month May Day 29 Year 19 67 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1-27-1875 | | 9. AGE (In years last birthday)
92 yrs. | 10. IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
At Home | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore County | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John Murk | | | | 14. MOTHER'S MAIDEN NAME
Mary Blum | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT Address
Carroll L. Pfeiffer - 645 Coventry Rd. #4 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thrombosis
DUE TO (c) Diverterculitis of Sigmoid Colon | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 yrs
4 days
2 yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Generalized arterio Sclerosis | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Sept 5 - 19 30 , to May 29 , 19 67 , that (I) was last saw the deceased alive on May 27 19 67 , and that death occurred at 11:54 P.M. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Earl L. Chambers | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
5/31/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Earl L. Chambers | | | | 22d. ADDRESS
4108 Liberty Hts Balto. Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
6-1-67 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR ADDRESS
Ellsworth Armacost -4600 Liberty Hghts. | | | | 25a. REC'D BY REGISTRAR
JUN 1 1967 | | 25b. REGISTRAR'S SIGNATURE
J Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02320

RECEIVED IN DEATH

02320

RECEIVED

10

10

10

10

10

10

10

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06380

CERTIFICATE OF DEATH

06370

| | | | | | | | |
|---|--|---|--|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore Co.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>md.</u> b. COUNTY <u>BalTo.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | | | | c. LENGTH OF STAY IN 1b
<u>4 yrs</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Aged Woman's & Men's Home</u> | | | | d. STREET ADDRESS
<u>504 Delaware Ave.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Annette</u> Middle <u>Phibbs</u> Last <u>Phibbs</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>28</u> Year <u>1967</u> | | | |
| 5. SEX
<u>F.</u> | | 6. COLOR OR RACE
<u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>July 18-1876</u> | |
| 9. AGE (In years last birthday)
<u>90</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (County & State, or foreign country)
<u>md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Phibbs, James</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Higle, Josephine</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>no</u> | | | | 16. SOCIAL SECURITY NO.
<u>215 48 7946</u> | | 17. INFORMANT
<u>M. Elta McEneaney</u> Address <u>615 Chestnut Ave</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac insufficiency</u>
DUE TO (b) <u>Arteriosclerotic heart disease</u>
DUE TO (c) <u>Generalized chronic arteriosclerosis, systemic.</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>Terminal</u>
<u>years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>March 3, 1960</u> , to <u>May 28, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 28, 1967</u> , and that death occurred at <u>2 A.M.</u> from causes on and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Edwin B. Jarrett</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>5/28/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Edwin B. Jarrett, M.D.</u> | | | | 22d. ADDRESS
<u>11 East Chase St., City-2.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>May 31, 67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Govans Presbyterian</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Towson, Md. Balto.</u> | |
| 24. FUNERAL DIRECTOR
<u>Wm. Cook-Brooks Towson, Towson, Md.</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>MAY 31 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

00330

CERTIFICATE OF WORK

00330

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D. C. 20250

[Faint, mostly illegible text and markings, possibly including a signature and date, are visible across the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06381

CERTIFICATE OF DEATH

07844

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore County MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Howard | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Mount Wilson | | c. LENGTH OF STAY IN 1b
5 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Mount Wilson State Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First HARRY Middle CORNELIUS Last PIERCE | | 4. DATE OF DEATH
Month MAY Day 18 Year 1967 | |
| 5. SEX
M. | 6. COLOR OR RACE
N. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3-16-06 |
| 9. AGE (In years lost birthday)
61 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABORER | |
| 11. BIRTHPLACE (County & State, or foreign country)
Ind. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JOHN PIERCE | | 14. MOTHER'S MAIDEN NAME
ANNIE BUTLER | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
231-10-5326 | |
| 17. INFORMANT
Records, Mount Wilson State Hospital | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) FAR ADVANCED PULMONARY TUBERCULOSIS
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
W. Newcomer | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
Wm. Newcomer, M.D., Superintendent Mount Wilson, Maryland | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF
May 22, 1967 | 23c. NAME OF CEMETERY OR CREMATORY
St. Mary's Cemetery | 23d. LOCATION (City or town) (County) (State)
Baltimore, Md. |
| 24. FUNERAL DIRECTOR
Frank H. Newell, Pikesville, Md. | | 25a. REC'D BY REGISTRAR
Charles Jua
DATE JUN 7 1967 | |

1883

STATE OF TEXAS

[Faint, mostly illegible text and markings on a document form, possibly a deed or legal record. The text is mirrored and appears to be bleed-through from the reverse side of the page.]

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06382

CERTIFICATE OF DEATH

06371

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MD. b. COUNTY BALTO. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CATONSVILLE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CATONSVILLE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
9 OVERBROOK ROAD | | d. STREET ADDRESS
9 OVERBROOK ROAD | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
MINNIE C. POOLE | | 4. DATE OF DEATH
Month Day Year
MAY 31, 1967 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1-16-1883 |
| 9. AGE (In years lost birthday)
84 yrs. | | 10. IF UNDER 1 YEAR
Months Days | 11. IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country)
Maryland |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Wm. Frankle | |
| 14. MOTHER'S MAIDEN NAME
Margaret Bauer | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | |
| 16. SOCIAL SECURITY NO.
220-44-5540 | | 17. INFORMANT
Address
Mrs. Thelma Johnson, 345 Martingale Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion, Acute
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic Heart Disease
DUE TO
(c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH
Sudden
6 mos. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Aug. , 19 63 , to May 1967 , 19 67 , that (I) (we) saw the deceased alive on May 3 , 19 67 , and that death occurred at 11:45M from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Leo J. Gaver | | 22b. DATE SIGNED
5/31/67 | 22c. PHYSICIAN'S NAME (Type)
LEO J. GAVER |
| 22d. ADDRESS
1 MALLOW HILL ROAD | | 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
6-3-1967 | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery |
| 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | 23e. REC'D BY REGISTRAR
JUN 2 1967 | |
| 24. FUNERAL DIRECTOR
HOWARD H. HUBBARD 4107 WILKENS AVE. 21229 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

06383

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8 Film #G389 6/2/67 pc

CERTIFICATE OF DEATH

06372

| | | | |
|--|----------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
St. Josephs Hospital | | d. STREET ADDRESS
321 East 30th Street | |
| 3. NAME OF DECEASED (Type or print)
First John Middle Thomas Last POTEET | | 4. DATE OF DEATH
Month May Day 28 Year 19 67 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8-28-93 91 |
| 9. AGE (In years last birthday)
75 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Maintenance retired | | 10b. KIND OF BUSINESS OR INDUSTRY
Self | |
| 11. BIRTHPLACE (County & State, or foreign country)
Harford County, Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Sheffield Poteet | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
218-18-1210A | |
| 17. INFORMANT
Mrs. Mary Poteet | | Address
321 E. 30th St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia involving the right and left lungs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure secondary to arterio-sclerotic and rheumatic heart disease.
(c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (A) (this hospital) attended the deceased from May 19 , 19 67 , to May 28 19 67 , that (A) (we) last saw the deceased alive on May 28 19 67 , and that death occurred at 8:20 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Lawrence F. Misanik | | 22b. DATE SIGNED
May 29, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Lawrence F. Misanik, M.D. | | 22d. ADDRESS
7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
6/1/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Goodwill Church Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Harford County, Md. | |
| 24. FUNERAL DIRECTOR
John A. Moran, Inc. | | 25a. REC'D BY REGISTRAR
Charles Judge | |
| 25b. REGISTRAR'S SIGNATURE
John A. Moran, Inc. | | 25c. DATE
MAY 31 1967 | |

08378

RECORDS OF THE

08380

1. The first part of the report is a general statement of the work done during the year. It is a summary of the work done by the various departments and is intended to give a general impression of the work done during the year.

2. The second part of the report is a detailed statement of the work done during the year. It is a summary of the work done by the various departments and is intended to give a general impression of the work done during the year.

3. The third part of the report is a detailed statement of the work done during the year. It is a summary of the work done by the various departments and is intended to give a general impression of the work done during the year.

4. The fourth part of the report is a detailed statement of the work done during the year. It is a summary of the work done by the various departments and is intended to give a general impression of the work done during the year.

5. The fifth part of the report is a detailed statement of the work done during the year. It is a summary of the work done by the various departments and is intended to give a general impression of the work done during the year.

6. The sixth part of the report is a detailed statement of the work done during the year. It is a summary of the work done by the various departments and is intended to give a general impression of the work done during the year.

7. The seventh part of the report is a detailed statement of the work done during the year. It is a summary of the work done by the various departments and is intended to give a general impression of the work done during the year.

8. The eighth part of the report is a detailed statement of the work done during the year. It is a summary of the work done by the various departments and is intended to give a general impression of the work done during the year.

9. The ninth part of the report is a detailed statement of the work done during the year. It is a summary of the work done by the various departments and is intended to give a general impression of the work done during the year.

10. The tenth part of the report is a detailed statement of the work done during the year. It is a summary of the work done by the various departments and is intended to give a general impression of the work done during the year.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06384

CERTIFICATE OF DEATH

06373

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland b. COUNTY
Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 21234 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | d. STREET ADDRESS
34 Dowling Circle | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Jack Warren POWELL | | 4. DATE OF DEATH
Month Day Year
May 31, 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12-12-17 |
| 9. AGE (In years lost birthday)
49 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mr. Artisan Flooring | | 10b. KIND OF BUSINESS OR INDUSTRY
Mr. retail Inst. | 11. BIRTHPLACE (County & State, or foreign country)
Maryland |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Charles E. Powell | |
| 14. MOTHER'S MAIDEN NAME
Blanche Aban | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
WW2 | |
| 16. SOCIAL SECURITY NO.
215-18-8863 | | 17. INFORMANT
Family records | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary edema
1621 DUE TO congestive heart failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Inoperable carcinoma of the lung
DUE TO (c) Arteriosclerosis. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 6, 19 67 , to May 31, 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 31, 19 67 , and that death occurred at 7:30AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Roberto Ferrer | | 22b. DATE SIGNED
May 31, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Roberto Ferrer, M.D. | | 22d. ADDRESS
7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
6/3/67 | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | 23d. LOCATION (City or Town) (County) (State)
Balt. |
| 24. FUNERAL DIRECTOR
John Burns Sons | | 25a. REC'D BY REGISTRAR
DATE JUN 5 1967 | |
| ADDRESS
Towson, Md. 21204 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

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RESEARCH OF DEPT.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06385

CERTIFICATE OF DEATH

06374

| | | | |
|--|-----------------------------|--|---------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> | |
| c. LENGTH OF STAY IN lb <u>2 days</u> | | 03, 1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater BALTIMORE MEDICAL CENTER</u> | | d. STREET ADDRESS <u>6123 FAIRIS ROAD</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>FRANCES VERNON Preston</u> | | 4. DATE OF DEATH <u>MAY 15 1967</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>CAU</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10/7/84</u> |
| 9. AGE (In years last birthday) <u>82</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>RETIRED</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE CO., Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Charles Preston</u> | | 14. MOTHER'S MAIDEN NAME <u>Hildt</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNK.</u> | | 16. SOCIAL SECURITY NO. <u>21705-9822</u> | |
| 17. INFORMANT <u>Patients chart</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4221</u> <u>respiratory arrest</u>
DUE TO (b) <u>cerebrovascular accident</u>
DUE TO (c) <u>ASCVD</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 mins</u>
<u>3 days</u>
<u>undet.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5-13</u> , 19 <u>67</u> to <u>5-15</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>5-15</u> , 19 <u>67</u> , and that death occurred at <u>8:20</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>V.R. Batoyon</u> | | 22b. DATE SIGNED <u>5-15-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>V. R. BATOYON</u> | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>5/18/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>PROSPECT HILL</u> | | 23d. LOCATION (City or Town) (County) (State) <u>TOWSON BALTO. MD.</u> | |
| 24. FUNERAL DIRECTOR <u>John Burns Sons</u> | | 25a. REC'D BY REGISTRAR <u>MAY 22 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

03378

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в руб.
Тел.

АССД
Центральный архив
Тел. 100000

2-12-61

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2-12-61

2-12-61

В.Р. БИДЮН
100000

06386

CERTIFICATE OF DEATH

06375

| | | | | | | | |
|--|----------------------------------|---|--|--|--------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
e. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Phoenix | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Phoenix 21131 03.1 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Cooper Road | | | | d. STREET ADDRESS
Cooper Road | | | |
| 3. NAME OF DECEASED
(Type or print) Charles Marion Price | | | | 4. DATE OF DEATH
Month May Day 20 , Year 1967 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 18, 1869 | 9. AGE (In years last birthday)
98 yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY
Gen. farming | | 11. BIRTHPLACE (County & State, or foreign country)
Phoenix, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Robert Oliver Price | | | | 14. MOTHER'S MAIDEN NAME
Elenor Royston | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
220-54-6542 | | 17. INFORMANT
Mrs. Elenor P. Shepperd | | Address Cooper Road Phoenix, Md. 21131 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebro-vascular accident
422.1 DUE TO Arteriosclerotic Cardiovascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 days
years. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
none | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
none | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 1964 to May 20, 1967 , that (I) (was) last saw the deceased alive on May 17, 1967 , and that death occurred at 6 A.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
James F. White, Jr. | | | | 22b. DATE SIGNED
5/20/67 | | 22c. PHYSICIAN'S NAME (Type)
James F. White, Jr. M.D. | |
| 22d. ADDRESS
Jarrettsville, Md. 21084 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/23/1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Clynmalira | | 23d. LOCATION (City, town or county) (State)
Monkton, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Charles E. Kurtz | | | | 25a. REC'D BY REGISTRAR
MAY 23 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |
| ADDRESS
Jarrettsville, Md. 21084 | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03380

03380

Baltimore

Baltimore

Baltimore

2131

Phoenix

98 yrs.

Phoenix

Cooper Road

Cooper Road

1947 30

Marion Price

Marion Price

Marion Price 8, 1889

Marion Price 8, 1889

Marion Price 8, 1889

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Marion Price 8, 1889

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06388

CERTIFICATE OF DEATH

06377

| | | | | | | | |
|--|--------------------------------|---|--|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Dundalk Md.</u> | | c. LENGTH OF STAY IN 1b
<u>50 yrs</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Dundalk Md.</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>403 New Pittsburgh Ave.</u> | | | | d. STREET ADDRESS
<u>302 Solleys Pt. Rd.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Henry</u> Middle <u>Osborne</u> Last <u>Pryor</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>24</u> Year <u>1967</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>Col</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Sept. 6, 1892</u> | | 9. AGE (In years lost birthday)
<u>74</u> yrs. | IF UNDER 1 YEAR
Months <u>8</u> Days <u>18</u> | IF UNDER 24 HRS.
Hours <u>-</u> Min. <u>-</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Crane Operator</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Ship Yard</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Keyville, Va.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>Samuel Pryor</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Virginia Green</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>213-07-4111</u> | | 17. INFORMANT
<u>Horace Pryor</u> Address <u>301 Pine St.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Uremia</u>
DUE TO (c) <u>Arteriosclerosis</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 day</u>
<u>3</u>
<u>5 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>50</u> , to <u>May 24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 24</u> , 19 <u>67</u> , and that death occurred at <u>3 PM</u> , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>William C. Wade</u> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>May 24, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>William C. Wade, M.D.</u> | | | | 22d. ADDRESS
<u>140 Oak Avenue Dundalk Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>5-27-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Mt. Calvary Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Maryland</u> | |
| 24. FUNERAL DIRECTOR
<u>Charles R. Law</u> ADDRESS <u>802 Madison Ave., Balto., Md.</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>MAY 24 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

57630

28620

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06387

CERTIFICATE OF DEATH

06376

| | | | | | | | |
|--|----------------------------------|---|---|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY - | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | | c. LENGTH OF STAY IN fb | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville Baltimore 30.4 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Shady Nook Nursing Home | | | | d. STREET ADDRESS
200 Mallow Hill Rd. | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print) | | First Mary Middle E. Brown Last Raley | | 4. DATE OF DEATH
Month May Day 23 Year 1967 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3/6/92 | | 9. AGE (In years last birthday)
75 yrs. | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Registered Nurse | | | 10b. KIND OF BUSINESS OR INDUSTRY
Retired | | 11. BIRTHPLACE (County & State, or foreign country)
Freeland, Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
- - - - Brown | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WW I | | 16. SOCIAL SECURITY NO.
220-24-1273 | | 17. INFORMANT
Edward Kaplitz | | Address
4603 Wilkens Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) arteriosclerotic Cardiovascular Disease
DUE TO Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) severe peripheral arteriosclerosis
DUE TO
(c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18b.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Oct. 12, 1962 , to May 23, 1967 , that (I) (we) last saw the deceased alive on May 22, 1967 , and that death occurred at 5:00 AM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Dr. Harry Knipp | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
5-23-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. Harry Knipp | | | | 22d. ADDRESS
4116 Edmondson Ave. 21229 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/25/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cemetery Baltimore, Maryland | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard | | ADDRESS
4107 Wilkens Ave. 21229 | | 25a. REC'D BY REGISTRAR
MAY 25 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

063889

1. NAME OF DECEASED
(Type or Print)

(Reckord)

Clinton Lang Reckord

2. DATE AND HOUR OF DEATH

May 9, 1967

063782 P.

3. PLACE OF DEATH IN BALTIMORE-MARYLAND

Baltimore County

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

Towson
St. Joseph's Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

Harford

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Bel Air

D. STREET ADDRESS (If rural, give location)

163 North Williams Street

5. SEX

male

6. RACE

White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Oct. 18, 1886

9. AGE (In years last birthday)

80

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Auditor

10B. KIND OF BUSINESS OR INDUSTRY

Race Track

11. BIRTHPLACE (State or foreign country)

Harford Co., Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John Reckord

14. MOTHER'S MAIDEN NAME

Lydia A. Zimmerman

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

432-01-0241

17. INFORMANT (Write name and address)

Mrs. Isabel O'C. Reckord 163 N. Williams St. Bel Air, Maryland 21014

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Coronary Insufficiency

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

Acute

(B) Arterio-sclerotic heart disease 3 yrs.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

22. I certify that (I) (this hospital) attended the deceased from July 19 64 to May 9, 19 67

that (I) (we) last saw the deceased alive on May 9 19 67 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

C. Edward Leach

M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

5-10-67

23C. PHYSICIAN'S NAME (Type)

C. Edward Leach

M.D.

23D. ADDRESS

14 E. Eager St.

Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

May 12, 1967

24C. NAME OF CEMETERY or CREMATORY

Mountain Christian Church Cem.

24D. LOCATION

Joppa, Harford Co., Maryland

(City, town, or county)

(State)

VR A15 (4)
25M 1/67

25A. DATE RECD BY HEALTH DEPT.

MAY 16 1967

25B. NAME OF PHYSICIAN

Charles Judge

25C. FUNERAL DIRECTOR

Joseph William Foster

25D. ADDRESS

W. Broadway & Williams St. Bel Air, Maryland 21014

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

88503

CERTIFICATE OF DEATH

Reg. Dist. No.

06378

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH
o. COUNTY <u>Balto.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> | | c. LENGTH OF STAY IN 1b <u>20 years</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Notre Dame Motherhouse</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Egwing Sr. Mary Reich</u> | | 4. DATE OF DEATH <u>May 11 1967</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 26, 1882</u> |
| 9. AGE (In years last birthday) <u>84</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Religious</u> | 11. BIRTHPLACE (State or foreign country) <u>Prussia</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>Germany</u> | | 13. FATHER'S NAME <u>Reich, Anthony</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Blum, Anna</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | |
| 16. SOCIAL SECURITY NO. <u>218-34-3692</u> | | 17. INFORMANT <u>JL Sr. M. Ernest</u> Address <u>6401 N. Charles St.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic Ca</u>
DUE TO (b) <u>Primary Site Not Determined</u>
DUE TO (c) <u>ASCVD</u>
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>11-9</u> , 19 <u>66</u> , to <u>5-11</u> , 19 <u>67</u> , that I last saw the deceased alive on <u>5-7-10</u> , 19 <u>67</u> , and that death occurred at <u>11:55 P.M.</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE <u>Robert J. Mahon</u> M.D. | | PHYSICIAN'S NAME (Type) <u>Robert J. Mahon, M.D.</u> <u>204 E. Joppa Road Towson, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>May 15, 1967</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Sisters Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Glen Arm, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond J. Currah</u> ADDRESS <u>817 Scarlett Dr. Towson, Md.</u> | | 24a. REC'D BY REGISTRAR <u>MAY 22 1967</u> | 24b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

CERTIFICATE OF DEATH

| | | |
|--|--|---|
| <p>DECEASED
 NAME
 SEX
 AGE
 DATE OF BIRTH
 PLACE OF BIRTH
 OCCUPATION
 MARITAL STATUS
 COLOR
 RELIGION
 EDUCATION
 PLACE OF DEATH
 DATE OF DEATH
 TIME OF DEATH
 CAUSE OF DEATH
 MANNER OF DEATH
 PLACE OF BURIAL
 DATE OF BURIAL
 NAME OF BURIAL PLACE
 NAME OF MINISTER
 NAME OF CLERGYMAN
 NAME OF CHURCH
 NAME OF FUNERAL HOME
 NAME OF CEMETERY
 NAME OF INTERMENT</p> | | <p>DATE OF DEATH
 TIME OF DEATH
 PLACE OF DEATH
 CAUSE OF DEATH
 MANNER OF DEATH
 PLACE OF BURIAL
 DATE OF BURIAL
 NAME OF BURIAL PLACE
 NAME OF MINISTER
 NAME OF CLERGYMAN
 NAME OF CHURCH
 NAME OF FUNERAL HOME
 NAME OF CEMETERY
 NAME OF INTERMENT</p> |
|--|--|---|

RECEIVED

MASSACHUSETTS STATE DEPARTMENT OF HEALTH
 BUREAU ONE
 19

MASSACHUSETTS STATE DEPARTMENT OF HEALTH
 BUREAU ONE
 19

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06391

CERTIFICATE OF DEATH

06380

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
o. COUNTY Baltimore Co.
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fullerton Rural | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fullerton Rural | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
7909 Belair Road | | d. STREET ADDRESS
7909 Belair Road | |
| 3. NAME OF DECEASED
(Type or print) Louisa A. Reider | | 4. DATE OF DEATH
Month May Day 8 Year 1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Nov. 8, 1907 |
| 9. AGE (In years last birthday) 59 yrs. | | 10. IF UNDER 1 YEAR
Months 5 Days 1 Hours 16 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Home Maker | | 10b. KIND OF BUSINESS OR INDUSTRY
Housewife | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore Co. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
George A. Klein Sr. | | 14. MOTHER'S MAIDEN NAME
Annie Brockmeyer | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
John H. Reider | | Address
7909 Belair Road | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic cancer, rebr. liver
DUE TO (b) Undefined primary co-
DUE TO (c) lobular or breast?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May 6, 1967 to 5-8-67 , that (I) (we) last saw the deceased alive on 5-8-67 , and that death occurred at 7P M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Dr. Riger | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. Riger | | 22d. ADDRESS
Overlea Avenue | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
May 12, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | | 23d. LOCATION (City or Town) (County) (State)
Kenwood Balto. Md. | |
| 24. FUNERAL DIRECTOR
Lassahn Funeral Home | | 25a. REC'D BY REGISTRAR
MAY 12 1967 | |
| 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12380

STATE OF TEXAS

12380

County of ... State of Texas
Know all men by these presents, that ...
for and to the use of ...
the sum of ... Dollars
to have and to hold unto the said ...
with all and singular rights and appurtenances thereto in anywise by law in anywise coming to the said ...
unto the said ...
I, the undersigned, ...
do hereby certify that the foregoing is a true and correct copy of the original as the same appears from the records of the County Clerk of the County of ... State of Texas.
Witness my hand and seal of office this ... day of ... A.D. 19...
County Clerk of the County of ... State of Texas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06392

CERTIFICATE OF DEATH

06381

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson
c. LENGTH OF STAY IN b
12-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 21206
d. STREET ADDRESS
6102 Hamilton Ave.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Joseph Frederick Reihl, Jr. | | 4. DATE OF DEATH
Month Day Year
May 22, 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 20, 1967 |
| 9. AGE (In years lost birthday)
yrs. 2 | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY
USA | |
| 13. FATHER'S NAME
Joseph Frederick Reihl, Sr. | | 14. MOTHER'S MAIDEN NAME
Norma Helen Massey | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
none | |
| 17. INFORMANT
Hospital Records | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Immaturity, Respiratory distress syndrome of the Newborn
DUE TO (b) 29 hours
DUE TO (c) 29 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH
29 hours | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour: o.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 20, 19 67 , to May 22, 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 22, 19 67 , and that death occurred at 2:35 M. , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Imelda Salanio | | 22b. DATE SIGNED
May 22, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Imelda Salanio, M.D. | | 22d. ADDRESS
7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/23/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Wesley Chapel Cem. | | 23d. LOCATION (City or Town) (County) (State)
Rock Hall, Md. | |
| 24. FUNERAL DIRECTOR
J. Willis Wells | | 25a. REC'D BY REGISTRAR
DATE MAY 25 1967 | |
| ADDRESS
Chestertown, Md. | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

18220

32832

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06393

CERTIFICATE OF DEATH

06382

| | | | | | | | |
|--|----------------------------------|---|---|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fullerton | | | c. LENGTH OF STAY IN IB
25yrs | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fullerton | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
4544 Ridge Road | | | | d. STREET ADDRESS
4544 Ridge Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Margaret Middle Reiners Last Reiners | | | | 4. DATE OF DEATH
Month 5 Day 6 Year 19 67 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6-2-1891 | | 9. AGE (In years lost birthday)
75 yrs. | IF UNDER 1 YEAR
Months 75 Days 75 | IF UNDER 24 HRS.
Hours 75 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machinist | | 10b. KIND OF BUSINESS OR INDUSTRY
Thau Mfg. Co. | | 11. BIRTHPLACE (County & State, or foreign country)
Fullerton Balto. Co. Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Henry H. Deigert | | | | 14. MOTHER'S MAIDEN NAME
Christine Michling | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
214-20-9375A | | 17. INFORMANT Address
Mrs Gladys Schaefer 1815 Wycliffe Road 21234 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coma -
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) Stroke -
DUE TO
(c) Atherosclerotic Cardiovascular Disease | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 9-13- , 19 66 , to 6 May , 19 67 that (I) (we) last saw the deceased alive on 6 May , 19 67 , and that death occurred at 10 p M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
John C. Hyle | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
5-8-67 | |
| 22c. PHYSICIAN'S NAME (Type)
JOHN C. Hyle | | | | 22d. ADDRESS
7527 Melrose Ball 36 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5-9-1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Co. Md. | |
| 24. FUNERAL DIRECTOR ADDRESS
Lassahn Funeral Home 7401 Belair Rd 36 | | | | 25a. REC'D BY REGISTRAR
MAY 11 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Jones | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

06394

06383

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTO.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u> 131 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3101 TEXAS AVE.</u> | | | | d. STREET ADDRESS <u>3101 TEXAS AVE.</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>HELEN SYLVIA REYNOLDS</u> First Middle Last | | | | 4. DATE OF DEATH Month <u>MAY</u> Day <u>24</u> Year <u>1967</u> | | | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>APRIL 1, 1898</u> | |
| 9. AGE (In years last birthday) <u>69</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u> | | 11. BIRTHPLACE (State or foreign country) <u>BALTO., MD.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>WILLIAM FINCK</u> | | 14. MOTHER'S MAIDEN NAME <u>CATHERINE HAMMEL</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>FAMILY</u> Address <u>SAME</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>metastatic carcinoma</u>
1992 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>followed surgical removal melanoma skin</u> DUE TO (c) <u>24y.</u> | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>5/18</u> , 19 <u>67</u> , to <u>5/22</u> , 19 <u>67</u> , that I last saw the deceased alive on <u>5/22</u> , 19 <u>67</u> , and that death occurred at <u>5:30</u> A.M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>1250 E. North Ave.</u> DATE SIGNED <u>5/26/67</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Dr. Sol Tanenbaum</u> | | | | Baltimore, Md. 21202 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>5-27-1967</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u> | | 22d. LOCATION (City, town, or county) (State) <u>TAYLOR AVE BALTO. MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Faltus Conklin</u> ADDRESS <u>5444 BELAIR RD.</u> | | | | 24a. REC'D BY REGISTRAR <u>MAY 29 1967</u> | | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2023

| | | | | | | | | | | | |
|-----------------------|--|----------------------|--|------------------------|--|--------------------|--|--------------------|--|---------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | DATE OF DEATH | |
| JAMES A. SMITH | | 45 | | M | | W | | 1978 | | 1978 | |
| PLACE OF BIRTH | | CITY | | STATE | | COUNTRY | | DATE OF DEATH | | TIME OF DEATH | |
| BALTIMORE | | BALTIMORE | | MD | | USA | | 1978 | | 10:00 AM | |
| CAUSE OF DEATH | | MANNER OF DEATH | | OCCUPATION | | EDUCATION | | RELIGION | | MARITAL STATUS | |
| HEART DISEASE | | NATURAL | | DRIVER | | HIGH SCHOOL | | CATHOLIC | | MARRIED | |
| DATE OF DEATH | | TIME OF DEATH | | PLACE OF DEATH | | CITY | | STATE | | COUNTRY | |
| 1978 | | 10:00 AM | | BALTIMORE | | MD | | USA | | | |
| SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF PHYSICIAN | | SIGNATURE OF CLERK | | SIGNATURE OF JUDGE | | SIGNATURE OF NOTARY | |
| | | | | | | | | | | | |

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased.

2. The cause of death should be stated in as much detail as possible, and should be based on the findings of the physician or other qualified person.

3. The manner of death should be stated as natural, accidental, or suicidal.

4. The occupation, education, and religion of the deceased should be stated.

5. The marital status of the deceased should be stated.

6. The date, time, and place of death should be stated.

7. The signature of the deceased, if known, should be stated.

8. The signature of the witness, if known, should be stated.

9. The signature of the physician, if known, should be stated.

10. The signature of the clerk, if known, should be stated.

11. The signature of the judge, if known, should be stated.

12. The signature of the notary, if known, should be stated.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|----------------------------------|--|---|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 06395 | | | | | | | | | |
| 06384 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY _____ | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonville | | | c. LENGTH OF STAY IN lb
5 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | | | | d. STREET ADDRESS
912 S. Brunswick Street | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
William J Riggs | | | First Middle Last | | 4. DATE OF DEATH
May 9 19 67 | | Month Day Year | | |
| 5. SEX
male | | 6. COLOR OR RACE
white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
May 24, 1913 | | 9. AGE (In years last birthday)
54 53 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
chauffer | | | 10b. KIND OF BUSINESS OR INDUSTRY
Maryland | | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
John F. Riggs | | | | | 14. MOTHER'S MAIDEN NAME
Bessie Kane | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes give war or dates of service) | | | 16. SOCIAL SECURITY NO.
220-07-5216 | | 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchogenic carcinoma of the lungs with metastatic lesions
1621 DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH _____ | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (this hospital) attended the deceased from May 4, 19 67 , to May 9, 19 67 , that (we) last saw the deceased alive on May 9, 19 67 , and that death occurred at 11:00 M., from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
Stella Wachslar | | | M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
5-10-67 | | | | |
| 22c. PHYSICIAN'S NAME (Type)
Stella Wachslar, M.D. | | | 22d. ADDRESS
SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 21228 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE THEREOF
5/13/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION (City, town or county) (State)
Baltimore, Maryland | | |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard | | | | | ADDRESS
4107 Wilkens Ave. 21229 | | 25a. REC'D BY REGISTRAR
MAY 11 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #14 Film #G388 5/17/67 pc

06396

CERTIFICATE OF DEATH

06385

| | | | | | |
|---|------------------------------|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland b. COUNTY
Baltimore | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Parkville | | c. LENGTH OF STAY IN 1b
25 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Parkville 03.1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
3017 Edgewood ave | | | d. STREET ADDRESS
3017 Edgewood ave | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Henry D. Riley | | | 4. DATE OF DEATH
Month Day Year
May 6, 19 67 | | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Nov 26 1903 | | 9. AGE (In years last birthday)
63 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Caretaker | | 10b. KIND OF BUSINESS OR INDUSTRY
Guest Home | | 11. BIRTHPLACE (County & State, or foreign country)
Virginia | |
| 13. FATHER'S NAME
William H. Riley | | | 14. MOTHER'S MAIDEN NAME
Sarah E. Riley Rousey | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
220-01-9492 | | 17. INFORMANT
Family Records Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchogenic Carcinoma
1621 DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH?
1 yr + |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Atherosclerotic Cardiac Vascular Disease | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 2-1 , 19 66 , to 5-6 , 19 67 , that (I) (we) lost saw the deceased alive on 5-6 19 67 , and that death occurred at 3p M, from causes on and on the date stated above. | | | | | |
| 22a. SIGNATURE
John C. Hyle | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
5-8-67 | |
| 22c. PHYSICIAN'S NAME (Type)
John C. Hyle MD | | 22d. ADDRESS
7527 Belair Road | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/10/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulane Valley Mem. | |
| 23d. LOCATION (City or Town) (County) (State)
Towson Balto. | | | | | |
| 24. FUNERAL DIRECTOR
C.F. EVANS & SON | | 8802 ADDRESS
Harford road | | 25a. REC'D BY REGISTRAR
MAY 11 1967 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

00330

00330

William H. Miller

1875

1017 Edwards Ave

Henry C. Miller

1875

Virginia

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

1875

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06397

06386

| | | | | | | | |
|---|----------------------------------|---|---|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
30 Yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
102 Bloomsbury Ave., | | | | d. STREET ADDRESS
102 Bloomsbury Ave., | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Irene Middle M. Last Ring | | | | 4. DATE OF DEATH
Month May Day 25 , Year 1967 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Oct. 1, 1890 | | 9. AGE (In years last birthday)
76 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
At Home | | 11. BIRTHPLACE (County & State, or foreign country)
Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Stephen J. Anderson | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address
Virginia A. Nonemaker 521 Windwood Rd. (12) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
4221
DUE TO
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last,
(b)
DUE TO
(c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 yr + |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Peptic ulcer - diverticulitis | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from December 6, 1950 , to May 25, 1967 , that (I) (we) last saw the deceased alive on May 8, 1967 , and that death occurred at 6 A. M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
John A. Nesbitt, Jr., M.D. | | | | 22b. DATE SIGNED
5-25-67 | | 22c. PHYSICIAN'S NAME (Type)
John A. Nesbitt, Jr., M.D. | |
| 22d. ADDRESS
1009 Frederick Road, Baltimore, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5-29-1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park | | 23d. LOCATION (City, town or county) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
G. Howard Strong 3207 W. North Ave., | | | | 25a. REC'D BY REGISTRAR
MAY 29 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles J. [Signature] | |

00333

00333

Selfsame

Married

Oceanville

30 Yrs.

Oceanville

112 Broadway Ave.,

101 Broadway Ave.,

Trans

King

Oct. 1, 1950

Female White

Longville

at home

Id.

Becker, J. Anderson

Unknown

Virginia A. Anderson 221 Lincoln Rd.

Battal 5-22-1952

London Park

U.S. Highway Station 3207 W. North Ave.

Id. 1952

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

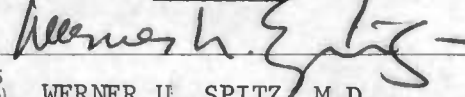

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #9 Film #G-88-5/17/67 pc
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06398

06387

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland | | b. COUNTY
Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fork | | c. LENGTH OF STAY IN 1b
35 yrs | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fork | | d. STREET ADDRESS
Robert's Fruit Stand | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Harford Road Fork, Md. | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
FRANCES | | First
MARY | | Middle
ROBERTS | | Last | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
7-16-1909 | |
| 9. AGE (In years last birthday)
57 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Waitress | | 11. BIRTHPLACE (State or foreign country)
New York | | 12. CITIZEN OF WHAT COUNTRY
U.S.A. | |
| 13. FATHER'S NAME
O'Donnell | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
213-169626 | | 17. INFORMANT
Mr Walter Roberts Box 25 Kingsville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
 | | EXAMINER'S NAME (Type)
WERNER U. SPITZ, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
Address (Street, city, town, or county) | | 22. DATE SIGNED
5-13-67 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5-16-1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Bel Air Memorial Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Bel Air Md. | |
| 24. FUNERAL DIRECTOR
Lassahn Funeral Home | | ADDRESS
7461 Belton Road | | 25a. REC'D BY REGISTRAR
MAY 15 1967 | | 25b. REGISTRAR'S SIGNATURE
 | |

00334

00334

Werner H. G. —

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06399

06388

| | | | |
|---|------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Lutherville</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>St. Joseph Hospital</u> | | d. STREET ADDRESS
<u>8504 Valley Field Rd.</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Harry</u> Middle <u>L.</u> Last <u>Roff</u> | | 4. DATE OF DEATH
Month <u>5</u> Day <u>23</u> Year <u>1967</u> | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>3/16/1895</u> |
| 9. AGE (In years last birthday)
<u>72</u> yrs. | | 10. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Post Office.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Harry Roff.</u> | | 14. MOTHER'S MAIDEN NAME
<u>Alice Hall.</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>Yes.</u> | | 16. SOCIAL SECURITY NO.
<u>War 1</u> | |
| 17. INFORMANT
<u>Mrs. Ann Hessler.</u> | | Address
<u>8504 Valleyfield rd</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Congenital heart failure</u>
DUE TO (b) <u>Arteriosclerosis cardiovascular disease</u>
DUE TO (c) _____
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Nelson S. de la Paz</u> | | 22b. DATE SIGNED
<u>5/23/67.</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Nelson S. de la Paz</u> | | 22d. ADDRESS
<u>St. Joseph's Hospital</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial.</u> | | 23b. DATE THEREOF
<u>5/26/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Baltimore Cem.</u> | | 23d. LOCATION (City, town or county) (State)
<u>Baltimore, Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>Leonard J. Ruck, inc. 5305 Harford Rd.</u> | | 25a. REC'D BY REGISTRAR
<u>MAY 24 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

22320

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 2 Film 6390 6/23/67 kk
CERTIFICATE OF DEATH

06400

06389

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CATONSVILLE | | | | c. LENGTH OF STAY IN 1b
03-1 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
FOREST HAVEN NURSING HOME | | | | d. STREET ADDRESS Dundalk Hotel
FOREST HAVEN NURSING HOME | | | |
| 3. NAME OF DECEASED
(Type or print) MORRIS ROSENFELD | | | | 4. DATE OF DEATH MAY 15, 19 67 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 73 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
STOREKEEPER | | 10b. KIND OF BUSINESS OR INDUSTRY
OWN | | 11. BIRTHPLACE (County & State, or foreign country)
BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
AARON ROSENFELD | | | | 14. MOTHER'S MAIDEN NAME
ELLA SIDENBERG | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES (U. S. 1 ARMY) | | 16. SOCIAL SECURITY NO.
219-01-3661A | | 17. INFORMANT Address
MR. EDWARD ROSENFELD, 913 TYSON PLACE #1 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4221 DANGEROUS INJURY
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) DEATH BY MYOCARDIAL INFARCTION
DUE TO
(c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 5/11 , 19 67 , to 5/15 , 19 67 , that (I) (we) last saw the deceased alive on 5/14 , 19 67 , and that death occurred at 2:45 PM from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
DR. JOHN SHAW | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
5/15/67 | |
| 22c. PHYSICIAN'S NAME (Type)
DR. JOHN SHAW | | | | 22d. ADDRESS
5800 EDMONDSON AVENUE | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL-CREMA | | 23b. DATE THEREOF
5/16/67 | | 23c. NAME OF CEMETERY OR CREMATORY
LOUDEN PARK | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR
SOL LEVINSON & BROS. INC., 6010 REIST., RD. | | | | 25a. REC'D BY REGISTRAR
MAY 22 1967 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | |

000000

UNITED STATES OF AMERICA

000000

RECEIVED
JAN 10 1964
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C.

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [illegible]

RE: [illegible]
[illegible]
[illegible]

[illegible]
[illegible]
[illegible]

[illegible]
[illegible]
[illegible]

[illegible]
[illegible]
[illegible]

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06401

06398

| | | | | | | | |
|---|------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH
e. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>md.</u> b. COUNTY <u>BALTIMORE</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Balto. 12</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Dulaney Towson Nursing Home</u> | | | | d. STREET ADDRESS
<u>356 Rosebank Ave.</u> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Jeannie McPherson</u> | | | | 4. DATE OF DEATH
Month <u>5</u> Day <u>12</u> Year <u>1967</u> | | | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Dec 4 1881</u> | | 9. AGE (in years last birthday) <u>85</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>OWN HOME</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Dumbarton, Scotland</u> | |
| 13. FATHER'S NAME
<u>DUNCAN McPherson</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Jeannie Mc Donald</u> | | 16. SOCIAL SECURITY NO.
<u>FAMILY RECORDS</u> | |
| 17. INFIRMANT Address | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary of Lung</u>
103X DUE TO <u>C Metastases to Brain</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>Old age</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 13 1967</u> , to <u>May 13 1967</u> , that (I) (we) last saw the deceased alive on <u>May 13 1967</u> , and that death occurred at <u>8:30</u> M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Michael Byerly</u> | | | | 22b. DATE SIGNED
<u>5/15/67</u> | | 22c. PHYSICIAN'S NAME (Type)
<u>M Paul Byerly</u> | |
| 22d. ADDRESS
<u>5420 York Rd Baltimore</u> | | | | 22e. REC'D BY REGISTRAR
<u>Charles Judge</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>5/15/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>PARKWOOD CEME.</u> | | 23d. LOCATION (City, town or county) (State)
<u>PARKVILLE, Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>John Bruno Lewis, Towson Md.</u> | | | | 25. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

10220

333

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|---|--|--|
| 06402 | | 06391 | |
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>7808 Brevort Rd</u> | | d. STREET ADDRESS
<u>7808 Brevort Rd</u> | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Alma</u> Middle <u>D.</u> Last <u>Schaefer</u> | | 4. DATE OF DEATH
Month <u>MAY</u> Day <u>25</u> Year <u>1967</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OF RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>2-3-1913</u> |
| 9. AGE (In years last birthday)
<u>54</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>TAILORING</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u> </u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Baltimore</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>George J. Dolle</u> | | 14. MOTHER'S MAIDEN NAME
<u>Kessner</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u> </u> | |
| 17. INFORMANT
<u>John D Schaefer - 7807 Brevort Rd #7</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>11 Carcinoma - Colon with metastasis</u>
1538 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u> </u>
(c) <u>Gleucoma - Both eyes</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>8 months</u>
<u>- 1 yr.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>None</u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | 20f. (City or town) (County) (State)
<u> </u> |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 18</u> , 19 <u>66</u> , to <u>May 25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 25</u> , 19 <u>67</u> , and that death occurred at <u>6:45</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Earl L. Chambers</u> | | 22b. DATE SIGNED
<u>5/27/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Earl L. Chambers</u> | | 22d. ADDRESS
<u>4108 Liberty Hts Baltimore Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 23b. DATE THEREOF
<u>5-29-67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Dulaney Valley Memorial Gardens - Cockeysville, Md</u> | 23d. LOCATION (City or Town) (County) (State)
<u> </u> |
| 24. FUNERAL DIRECTOR
<u>Ellsworth Armacost - 4600 Liberty Hts Ave</u> | | 25a. REC'D BY REGISTRAR
<u>MAY 31 1967</u> | 25b. REGISTRAR'S SIGNATURE
<u>J Charles Judge</u> |

1950

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06403

CERTIFICATE OF DEATH

06392

| | | | | | | | |
|---|---|---|-------------------------------------|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Randallstown</u> | | c. LENGTH OF STAY IN 1b
<u>1 day</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> <u>21215</u> <u>3014</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Baltimore County Hospital</u> | | | | d. STREET ADDRESS
<u>2721 Cyburn Ave</u> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>NATHAN (Norman) R. Scheer</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>28</u> Year <u>1967</u> | | | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>11-15-02</u> | 9. AGE (In years last birthday)
<u>64</u> yrs. | 10. IF UNDER 1 YEAR
Months <u>6</u> Days <u>4</u> | | 11. IF UNDER 24 HRS.
Hours <u>12</u> Min. <u>00</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>MACHINIST</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Retired</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Russia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Reuben Scheer</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Fannie Karasik</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>NO YES</u> <u>WW 1 Army</u> | | 16. SOCIAL SECURITY NO.
<u>212-09-8106</u> | | 17. INFORMANT
Address <u>Mrs. Betty Scheer, 2721 Cyburn Avenue</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>pressure myocardial infarction</u>
DUE TO (b) <u>Coronary artery thrombosis</u>
DUE TO (c) <u>pswd.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>1201</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>12 hrs.</u>
<u>12 hrs.</u>
<u>YEARS</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5-27</u> , 19 <u>67</u> to <u>5-28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-19-67</u> and that death occurred at <u>8:10</u> A.M. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Angelita To Paid</u> | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
<u>5-28-67</u> | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>ANGELITA TO PAID</u> | | 22d. ADDRESS
<u>EDM -</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>5/29/67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Hebrew friendship -</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Maryland</u> | | | |
| 24. FUNERAL DIRECTOR
<u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>JUN 6 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02520

60220

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06404

CERTIFICATE OF DEATH

06393

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md.
b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lutherville | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Chesapeake Manor N. Home | | d. STREET ADDRESS
1719 Greenspring Dr. | |
| 3. NAME OF DECEASED (Type or print)
Frederick William Scheller | | 4. DATE OF DEATH
Month May Day 31 Year 1967 | |
| 5. SEX
M | 6. COLOR OR RACE
Cauc. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
June 25, 1886 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Supervisor, C.&P. Telephone Co. | | 10b. KIND OF BUSINESS OR INDUSTRY
Telephone Co. | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Md. |
| 13. FATHER'S NAME
Frederick William Scheller | | 14. MOTHER'S MAIDEN NAME
Margaret E. Wilson | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
212 05 0612 | 17. INFORMANT
Mrs. Mary Harvey, Lutherville, Md. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH
10 YRS |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from May 1967 to 5/31 , 1967, that (I) (we) lost the deceased alive on May 1967 , and that death occurred at 2:15 P. M, from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
<i>William A. Pillsbury</i> | | 22b. DATE SIGNED
6-1-67 | |
| 22c. PHYSICIAN'S NAME (Type)
William A. Pillsbury | | 22d. ADDRESS
2060 York Rd., Timonium, Md. | |
| 23a. BURIAL, CREMATION, BURIAL (Specify) | 23b. DATE THEREOF
June 3, 67 | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Memorial | 23d. LOCATION (City or Town) (County) (State)
Parkville, Baltimore, Md. |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson, Towson, Md. | | 25a. REG'D BY REGISTRAR
JUN 5 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

58

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06405

CERTIFICATE OF DEATH

06394

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
c. LENGTH OF STAY IN 1b Life | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital | | d. STREET ADDRESS 9630 Alda Drive
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Henry Middle C. Last Schoeberlein | | 4. DATE OF DEATH
Month May Day 1 Year 1967 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/31/1904 |
| 9. AGE (In years last birthday) 65 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist | |
| 10b. KIND OF BUSINESS OR INDUSTRY Crown Cork & S | | 11. BIRTHPLACE (County & State, or foreign country) Baltimore | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME John Schoberlein | |
| 14. MOTHER'S MAIDEN NAME Fredricka Boehner | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | |
| 16. SOCIAL SECURITY NO. 216-01-5428 | | 17. INFORMANT Family records Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intraventricular hemorrhage, left hemisphere of brain
DUE TO (b) Atherosclerotic heart disease with hypertension.
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. 19
p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that 10 (this hospital) attended the deceased from May 1, 1967 , to May 1, 1967 , that 10 (we) last saw the deceased alive on May 1, 1967 , and that death occurred at 9:05 p M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Juana S. Cockburn | | 22b. DATE SIGNED May 2, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) Juana S. Cockburn, M.D. | | 22d. ADDRESS 7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 5/5/67 | 23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park Balto. | 23d. LOCATION (City or Town) (County) (State) Md. |
| 24. FUNERAL DIRECTOR C.F. EVANS & SON 8802 Harford road | | 25a. REC'D BY REGISTRAR MAY 3 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

00230

REPORT OF DEATH

00100

NAME OF DECEASED
DATE OF DEATH
PLACE OF DEATH

DATE OF BIRTH
PLACE OF BIRTH
OCCUPATION

CAUSE OF DEATH
MANNER OF DEATH

EDUCATION
MARRIAGE

RELIGION
SOCIETY

HOUSING
VEHICLE

EMPLOYMENT
INCOME

HEALTH
DISABILITY

REMARKS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|------------------------------------|--|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 06406 Item 2 Film G388 5/11/67 kk CERTIFICATE OF DEATH 06395 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY G B M C. County Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson
c. LENGTH OF STAY IN 1b MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Baltimore Medical Center | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Utherville, Md. 21149
d. STREET ADDRESS Princess Issema Hotel e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) Mabel C Schuchart | | | 4. DATE OF DEATH MAY 7 1967 | | | 5. SEX Female | | | 6. COLOR OR RACE Cau. | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH 2/18/85 | | | 9. AGE (In years last birthday) 82 yrs. | | | 10. IF UNDER 1 YEAR 4 IF UNDER 24 HRS. 4 | | |
| 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland | | | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME Joseph Linthicum | | | | | | 14. MOTHER'S MAIDEN NAME Smith | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | | | 16. SOCIAL SECURITY NO. 143-05-4288 | | | | | |
| 17. INFORMANT PATIENTS CHART | | | | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
434.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure
DUE TO (c) Respiratory difficulty secondary to | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Abdominal distension by fluid due to paralytic ileus | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on MAY 3 1967 , and that death occurred at 3:15 A.M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE Seock, e. Chang | | | | | | 22b. DATE SIGNED May 7. 67 | | | | | |
| 22c. PHYSICIAN'S NAME (Type) G B M C | | | | | | 22d. ADDRESS G B M C | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | 23b. DATE THEREOF 5/10/67 | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | | | | | | 23d. LOCATION (City, town or county) (State) Pikesville, Md. | | | | | |
| 24. FUNERAL DIRECTOR Wm. F. Tibner & Sons | | | | | | 25a. REC'D BY REGISTRAR Charles Judge | | | | | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | DATE MAY 8 1967 | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06407

06396

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE COUNTY GEN HOSP MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural-Randallstown | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Randallstown 21133 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Balt. Co. General Hospital | | d. STREET ADDRESS
3705 Cassen Road | |
| 3. NAME OF DECEASED (Type or print)
First CHARLES Middle L. Last SCHWARTZ Jr. Jr. | | 4. DATE OF DEATH
Month 5 Day 10 Year 1967 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 77
3/4/1890 Yrs. 88 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Stationary Engineer | | 10b. KIND OF BUSINESS OR INDUSTRY
Cold Storage | |
| 11. BIRTHPLACE (County & State, or foreign country)
Balt. Co. Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Charles L. Schwartz | | 14. MOTHER'S MAIDEN NAME
Lydia Raver | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
212-22-4776 | |
| 17. INFORMANT
Mrs. Florence L. Schwartz-3705 Cassen Rd. | | Address Randallstown | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) CORONARY THROMBOSIS
DUE TO
(c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 5/10, 1967 to 5/10, 1967 that (I) (we) last saw the deceased alive on 5/10, 1967 , and that death occurred at 7 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Mariando A. Tolentino M.D. | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | 22b. DATE SIGNED
5/10/67 |
| 22c. PHYSICIAN'S NAME (Type)
MARIANDO A. TOLENTINO | | 22d. ADDRESS
301 ST. PAUL ST. BALTIMORE 21202 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
5/13/67 | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge Cemetery | 23d. LOCATION (City or Town) (County) (State)
Pikesville, Md. 21208 |
| 24. FUNERAL DIRECTOR
Loring Byers-8728 Liberty Rd. Randallstown, Md. | | 25a. REC'D BY REGISTRAR
MAY 15 1967 | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

6407

6407

General-landfill.com

landfill.com 21102

Inf. Co. General Hospital

3705 Carson Road

Stationary Engineer

Cold Storage

Inf. Co. No.

Charles A. Roberts

Lydia Haven

No

3705-4705

Inf. Co. No. 3705 Carson Rd.

2103/87

David Ridge Cemetery

2103/87

Inf. Co. No. 3705 Carson Rd.

MAY 12 1987

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06408

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06397

| | | | |
|---|------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lutherville
c. LENGTH OF STAY IN 1b
MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
1101 Hemsley Court | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lutherville, 21093
d. STREET ADDRESS
1101 Hemsley Court
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First
Marie
Middle
C.
Last
Scotney | | 4. DATE OF DEATH
Month
May
Day
2
Year
1967 | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/17/1916 |
| 9. AGE (In years last birthday)
50 yrs. | | 10. BIRTHPLACE (County & State, or foreign country)
Baltimore, Md. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Secretary | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
William A. Kammeer | | 14. MOTHER'S MAIDEN NAME
Mary V. Collins | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
213-01-1501 | |
| 17. INFORMANT
Herbert M. Scotney | | Address
(Same) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Breast
170X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b)
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from April, 1967 to May 2, 1967 , that (I) (we) last saw the deceased alive on May 2, 1967 , and that death occurred at 10 P M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
William H. Fusting | | 22b. DATE SIGNED
5-4-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. William H. Fusting | | 22d. ADDRESS
4230 Loch Raven Blvd. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/6/1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | | 23d. LOCATION (City, town or county) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | 25a. REC'D BY REGISTRAR
DATE 5 1967 | |
| 25b. REGISTRAR'S SIGNATURE
J Charles Judge | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06403

CERTIFICATE OF DEATH

06398

| | | | |
|---|---------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTO</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>BALTO</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>ESSEX</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>ESSEX</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>417 VOGTS LANE</u> | | d. STREET ADDRESS
<u>417 VOGTS LANE</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>EMANUEL</u> Middle <u>G.</u> Last <u>SHAPIRO</u> | | 4. DATE OF DEATH
Month <u>MAY</u> Day <u>19</u> Year <u>1967</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>SEPT. 21, 1902</u> |
| 9. AGE (In years lost birthday) <u>64</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>RET.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u> </u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>N.Y.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME
<u>JOSEPH SHAPIRO</u> | | 14. MOTHER'S MAIDEN NAME
<u> ?</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <u>167-28-5214</u> | |
| 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u>
<u>4801</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>HYPERTENSIVE CARDIO-VASCULAR DISEASE</u>
DUE TO
(c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>11 YEARS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>APR. 13, 1956</u> , to <u>MAY 19, 1967</u> , that (I) (we) last saw the deceased alive on <u>MAY 12, 1967</u> , and that death occurred at <u>6:45 A.M.</u> , from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Joseph Miceli</u> | | 22b. DATE SIGNED
<u>5/19/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>JOSEPH MICELI, M.D.</u> | | 22d. ADDRESS
<u>108 S. TAYLOR AVE ESSEX, MD 21221</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>5/22/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Fountain Park</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Balto, Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>J. H. Connelly, Sr.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>MAY 23 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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UNITED STATES OF AMERICA

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UNITED STATES OF AMERICA
DEPARTMENT OF THE ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C. 20315

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06410

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06399

| | | | | | | | |
|---|------------------------------|---|-------------------------------------|--|---------------------------|---|-------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
On Way to St. Joseph Hospital | | | | d. STREET ADDRESS
1640 Thetford Road | | | |
| 3. NAME OF DECEASED (Type or print)
First James Middle Coleman Last Shipley, Sr. | | | | 4. DATE OF DEATH
Month 5 Day 23 Year 1967 | | | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12/23/21 | 9. AGE (In years last birthday)
45 yrs. | IF UNDER 1 YEAR
Months | IF UNDER 24 HRS
Days | IF UNDER 24 HRS
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Radar Engineer | | 10b. KIND OF BUSINESS OR INDUSTRY
Bendix Radio Corp. | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John William Shipley, Sr. | | | | 14. MOTHER'S MAIDEN NAME
Margaret Francis Gilbert | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
Yes | | 16. SOCIAL SECURITY NO.
220-07-5652 | | 17. INFORMANT
Family Records | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion Sudden
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Charles F. O'Donnell
EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D. | | | | 22. DATE SIGNED
May 26, 1967 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
May 26, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
John Burns Sons | | | | 25. REC'D BY REGISTRAR
MAI 26 1967 | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06411

CERTIFICATE OF DEATH

06400

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
2yr9mth 21dys | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Pearl Middle B Last Shumate | | 4. DATE OF DEATH
Month May Day 8 Year 1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Aug. 7, 1900 |
| 9. AGE (In years last birthday) yrs.
66 | | 10. IF UNDER 1 YEAR
Months 0 Oys 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Isaac Brown | | 14. MOTHER'S MAIDEN NAME
Rebecca Caffee | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
579-03-0349D | |
| 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic cardiovascular Heart Dis
DUE TO
(c) Arteriosclerosis, Generalized, senile | | INTERVAL BETWEEN ONSET AND DEATH
acute
3 yrs.
3 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Decubitus Ulcers, Sacrum and right heel, Inf. with P.Aerugin | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from July 17, 1964 , to May 8, 1967 , that (I) (we) last saw the deceased alive on May 8, 1967 , and that death occurred at 7:15 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Anthony J. Young</i> | | 22b. DATE SIGNED
5-9-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Anthony J. Young, M.D. | | 22d. ADDRESS
Spring Grove State Hospital
Baltimore, Maryland 21228 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5-12-1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Washington Nat'l | | 23d. LOCATION (City or Town) (County) (State)
Fox Mullen, Pa | |
| 24. FUNERAL DIRECTOR
Matthew 131-1166 St. S.E. DC. | | 25. REC'D BY REGISTRAR
DATE MAY 12 1967 | |
| 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2122

00236

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06412

CERTIFICATE OF DEATH

06401

| | | | |
|---|------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTO.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>RANDALL TOWN</u> | | c. LENGTH OF STAY IN 1b
<u>8 DAYS</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>BALTO.</u> | | 30.4 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>BALTO COUNTY HOSPITAL</u> | | d. STREET ADDRESS
<u>5417 CRUMMER Avenue</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>KATHERINE</u> Middle <u>SIEGEL</u> Last <u>SIEGEL</u> | | 4. DATE OF DEATH
Month <u>5</u> Day <u>1</u> Year <u>1967</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>9-11-89</u> |
| 9. AGE (In years last birthday)
<u>77</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>AT HOME</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>MINNESOTA LATVIA</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>LEVI</u> XXXXXXXXXXXX <u>KIRSON</u> | | 14. MOTHER'S MAIDEN NAME
<u>BESSIE</u> <u>Israelson</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>NO</u> | |
| 17. INFORMANT
<u>MORTON H. PERRY, ESQ.,</u> | | Address
<u>EQUITABLE BLDG.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>GENERALIZED ARTEROSCLEROSIS</u>
<u>4500</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____
(c) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<u>2-6 DAYS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>CA OF PANCREAS WITH METASTASIS; DEHYDRATION</u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>19</u> o.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4/23/67</u> , 19 <u>67</u> , to <u>5/1/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/1/67</u> , 19 <u>67</u> , and that death occurred at <u>11:20 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Dr. Nathan Needle</u> M.D. | | 22b. DATE SIGNED
<u>5-1-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>NATHAN NEEDLE</u> | | 22d. ADDRESS
<u>PARK HEIGHTS AVENUE</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>5/3/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>BNAI ISRAEL</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>BALTIMORE, MARYLAND</u> | |
| 24. FUNERAL DIRECTOR
<u>SOL LEVINSON & BROS. IN C., 6010 REIST., RD.</u> | | 25a. REC'D BY REGISTRAR
<u>MAY 5 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>J. Charles Judge</u> | | | |

00230

CERTIFICATE OF DEATH

2013

NAME

DATE

TIME

PLACE

Cause of Death

1. Name of Deceased

2. Sex

3. Age

4. Race

5. Occupation

6. Education

7. Marital Status

8. Date of Birth

9. Date of Death

10. Time of Death

11. Place of Death

12. Cause of Death

13. Signature of Physician

14. Signature of Registrar

15. Signature of Coroner

VR A15 (4
15M 4-64

2)

Item 8 Film 6389-5/31/67

Item 8 Film 6389-5/31/67

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltic</u> | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE <u>MD.</u>
b. COUNTY <u>md.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural</u> | | c. LENGTH OF STAY IN 1b
<u>24 Days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Foxleigh Nursing Home</u> | | d. STREET ADDRESS
<u>3533 Reisterstown Rd</u> | |
| 3. NAME OF DECEASED (Type or print)
<u>Ida</u> | | 4. DATE OF DEATH
Month <u>May</u> Day <u>22</u> Year <u>1967</u> | |
| 5. SEX
<u>F</u> | | 6. COLOR OR RACE
<u>White</u> | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>9-21-1917</u> | |
| 9. AGE (In years last birthday)
<u>71</u> yrs. | | 10. FUNERAL 1 YEAR <input type="checkbox"/> FUNERAL 24 HRS. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Europe</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Abraham</u> | | 14. MOTHER'S MAIDEN NAME
<u>Rachael</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>124-05-4534</u> | |
| 17. INFORMANT
<u>Seymour Silberstein</u> | | Address
<u>Same</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of colon</u>
<u>1538</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____
DUE TO
(b) _____
(c) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 mo.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1946</u> to <u>5-22, 1967</u> , that (I) (we) last saw the deceased alive on <u>5-22, 1967</u> , and that death occurred at <u>3 p.m.</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Irvin Sauber</u> | | 22b. DATE SIGNED
<u>5-23-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>IRVIN SAUBER</u> | | 22d. ADDRESS
<u>6905 PARK HEIGHTS AVE</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>5/24/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Beth El</u> | | 23d. LOCATION (City, town or county) (State)
<u>Randallstown Md</u> | |
| 24. FUNERAL DIRECTOR
<u>Sydney S. Lewis & Son, Inc. Gaithersburg, Md</u> | | 25a. REC'D BY REGISTRAR
<u>MAY 24 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

10130

10130

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06414

06403

| | | | | | |
|--|---------------------------------------|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>md.</u> b. COUNTY <u>Balt. City</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | | | c. LENGTH OF STAY IN TB
<u>Unknown</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Greater Baltimore Med. Center</u> | | | d. STREET ADDRESS
<u>3016 Christopher Ave</u> | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Rose</u> Middle <u>Estelle</u> Last <u>Silverthorne</u> | | | 4. DATE OF DEATH
Month <u>5</u> Day <u>24</u> Year <u>1967</u> | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>Cau</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>10/10/1876</u> | | 9. AGE (In years last birthday)
<u>90</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HW</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>-</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Concord, Virginia</u> | |
| 13. FATHER'S NAME
<u>William Wilson</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Churn</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>223-70-6995</u> | | 17. INFORMANT
<u>Virginia Stevens</u> Address <u>3016 Christopher Ave</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>C.V.A.</u>
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
(c) _____
DUE TO _____
DUE TO _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4-14</u> , 19 <u>67</u> , to <u>5-24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-24</u> 19 <u>67</u> , and that death occurred at <u>2:45AM</u> , from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
<u>R. K. CHILLAR</u> | | | 22b. DATE SIGNED
<u>5/24/67</u> | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>RAM K. CHILLAR</u> | | | 22d. ADDRESS
<u>GR. BALTIMORE MED. CENTER BALTIMORE, MD.</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 23b. DATE THEREOF
<u>5-27-1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>NELSON CEMETERY</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>BALTIMORE CITY WDC MD.</u> | |
| 24. FUNERAL DIRECTOR
<u>Robert H. Watson</u> | | | 25a. RECEIVED BY REGISTRAR
<u>MAY 29 1967</u> | | |
| 25b. OTHER SIGNATURE
<u>Robert H. Watson</u> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4503

A.V.3

3-12-57 2-54 10

James M. Smith

Edith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2

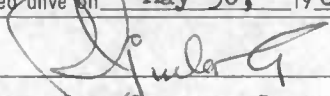
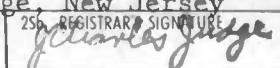
1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06415

06404

| | | | | | | | | | |
|--|--|--|--------------------------------------|---|--|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. LENGTH OF STAY IN TB
Hrs. | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland | | b. COUNTY
Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | | | d. STREET ADDRESS
16 Northwood Dr. | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Andrew | | | First Middle Last
SKERCHEK | | | 4. DATE OF DEATH
May 30, 1967 | | Month Day Year
May 30, 1967 | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
12-4-1907 | | 9. AGE (In years lost birthday)
59 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Butcher | | 10b. KIND OF BUSINESS OR INDUSTRY
Owner- | | 11. BIRTHPLACE (County & State, or foreign country)
New Jersey | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
John Skerchek | | | | 14. MOTHER'S MAIDEN NAME
Pearl Herila | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
Yes W. W. TWO | | 16. SOCIAL SECURITY NO.
145-09-9452 | | 17. INFORMANT
Natalie Skerchek, Same as # 2 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute hemorrhagic pancreatitis.
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Acute pulmonary edema | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 30, 1967 , to May 30, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 30, 1967 , and that death occurred at 11:45M , from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
 | | | | 22b. DATE SIGNED
May 31, 1967 | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
Reynaldo Orjuela-Gomez, M.D. | | | | 22d. ADDRESS
7620 York Rd., Towson, Md. 21204 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
June 3, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Clover Leaf Park | | 23d. LOCATION (City or Town) (County) (State)
Woodbridge, New Jersey | | | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204 | | | | 25a. REC'D BY REGISTRAR
JUN 5 1967 | | 25b. REGISTRAR'S SIGNATURE
 | | | |

6152

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ribbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06416

CERTIFICATE OF DEATH

06405

| | | | | | | | |
|---|----------------------------------|---|--|--|--|--|---|
| 1. PLACE OF DEATH
o. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE MARYLAND b. COUNTY BALTIMORE | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | | c. LENGTH OF STAY IN 1b
4 DAYS | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
EDGEMERE BALTIMORE COUNTY | | | d. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | | | d. STREET ADDRESS
3229 LYNCH ROAD | | | |
| 3. NAME OF DECEASED (Type or print)
First JOSEPH Middle NMI Last SMITH | | | | 4. DATE OF DEATH
Month MAY Day 10 Year 19 67 | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2/21/96 | | 9. AGE (In years lost birthday)
71 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABORER , RETIRED | | 10b. KIND OF BUSINESS OR INDUSTRY
STEEL CO. | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland EDGEMERE BALTO. COUNTY | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
FRANK STACHOWSKI | | | | 14. MOTHER'S MAIDEN NAME
CATHERINE TOMCZEWSKI | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW I | | 16. SOCIAL SECURITY NO.
213 09 15 41 | | 17. INFORMANT Address
CLINICAL RECORDS VAH FORT HOWARD, MARYLAND | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) CARCINOMA OF THE LUNG, RIGHT, WITH METASTASIS
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH
DAYS
UNKNOWN | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 5/6/1967 , to 5/10 , 19 67 , that (I) (we) last saw the deceased alive on 5/10 , 19 67 , and that death occurred at p. M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Carmelita A. Cendana | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
5-10-67 | |
| 22c. PHYSICIAN'S NAME (Type)
CARMELITA A. CENDANA, M.D. | | | | 22d. ADDRESS
VAH, FORT HOWARD, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
5/15/67 | 23c. NAME OF CEMETERY OR CREMATORY
HOLY ROSARY CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE COUNTY, MARYLAND | | |
| 24. FUNERAL DIRECTOR
John J. Duda | | | | 25a. REC'D BY REGISTRAR
MAY 15 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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Committee of Defense

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06417

CERTIFICATE OF DEATH

06406

| | | | | | | | |
|--|--|--|-------------------------|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY — | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Paradise Nursing Home | | | | d. STREET ADDRESS
6205 Marietta Ave. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
LILLIAN E. SMITH | | | | 4. DATE OF DEATH
Month Day Year
5 16 1967 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
3/6/83 | |
| 9. AGE (In years last birthday)
84 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Jacob Nelson | | | | 14. MOTHER'S MAIDEN NAME
Ida Lukun | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Nelson E. Smith-6205 Marietta Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized Arteriosclerosis
DUE TO Chronic Brain Syndrome
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Decubiti Multiple
DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
10 yrs.
5 yrs.
3 months |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | | 20f. (City or town) (County) (State)
5/16/67 | |
| 21. I certify that (I) (this hospital) attended the deceased from 2/13/66 to 5/16/67 , that (I) (we) last saw the deceased alive on 5/15/67 , and that death occurred at 2:10 A M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
W.E. McGrath | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
5/17/67 | |
| 22c. PHYSICIAN'S NAME (Type)
W.E. McGrath M.D. | | | | 22d. ADDRESS
1303 Frederick Rd. (214 38) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/19/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Memorial Pk | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
Robert C. Altenburg - 6009 Harford Rd. | | | | 25a. REC'D BY REGISTRAR
DATE MAY 18 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |
| Funeral Home, Inc. | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 17 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06418

06407

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTO</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>BALTO</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CATONSVILLE</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CATONSVILLE</u> 03-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>116 WOODLAWN AVE</u> | | d. STREET ADDRESS
<u>116 WOODLAWN AVE</u> | |
| 3. NAME OF DECEASED (Type or print) <u>RUTH J. SMULLEN</u>
First Middle Last | | 4. DATE OF DEATH <u>5/27</u> 19 <u>67</u>
Month Day Year | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/25/08</u> 59 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>NEW YORK</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
<u>HARRY BOLTON</u> | | 14. MOTHER'S MAIDEN NAME
<u>FLORENCE M. MULLEN</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<u>GEORGE C. SMULLEN</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Terminal phase of Metastatic</u>
<u>170X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ca of Breast</u> DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH
<u>Months.</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12/27/1966</u> to <u>5/28/1967</u> , that (I) (we) last saw the deceased alive on <u>5/23/1967</u> , and that death occurred at <u>2:00 P.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Adnan Sonmez</u> | | 22b. DATE SIGNED
<u>5/29/1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Adnan Sonmez</u> | | 22d. ADDRESS
<u>1011 Frederick Road Balt. Md. 21228</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>CREMATION</u> | 23b. DATE THEREOF
<u>5/30/67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>LOU DON PARK</u> | 23d. LOCATION (City or Town) (County) (State)
<u>BALTO MD.</u> |
| 24. FUNERAL DIRECTOR
<u>E.S. MALNABR</u> | | 25. REC'D BY REGISTRAR
<u>21228</u> | |
| 25a. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | DATE <u>JUN 1 1967</u> | |

10529

RECEIVED 10/10/1911

11130

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove from the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06413

CERTIFICATE OF DEATH

06408

| | | | |
|---|-------------------------------|--|--------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Baltimore</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | c. LENGTH OF STAY IN lb <u>11 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General Hosp.</u> | | d. STREET ADDRESS <u>3409 Kimbark Rd.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Kate L. Snyder</u> | | 4. DATE OF DEATH <u>May 11 1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8/4/80</u> |
| 9. AGE (In years last birthday) <u>86</u> yrs. | | 10. IF UNDER 1 YEAR <u>11</u> Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | |
| 11. BIRTHPLACE (Country & State, or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>America</u> | |
| 13. FATHER'S NAME <u>Leibel, Louis</u> | | 14. MOTHER'S MAIDEN NAME <u>Sord McKinis</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Carol Snyder</u> | | Address <u>Liberty Street - Sord</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>157X</u>
DUE TO (b) <u>La 7 pancreas</u>
DUE TO (c) <u>La 7 pancreas</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u>
p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5-11, 1967</u> , to <u>5-11, 1967</u> ; that (I) (we) last saw the deceased alive on <u>5-11, 1967</u> , and that death occurred at <u>9:45</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>[Signature]</u> | | 22b. DATE SIGNED <u>5-11-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Dr. Lai</u> | | 22d. ADDRESS <u>B.C. G. Hospital</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>5/13/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Randallstown, Md. 21133</u> | |
| 24. FUNERAL DIRECTOR <u>Loring Byers-8728 Liberty Rd. Randallstown, Md.</u> | | 25a. REC'D BY REGISTRAR <u>MAY 15 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

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01430

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MD

Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|---|---|---|--|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 06420 | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | 06409 | |
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>BALTIMORE</u> 12 | | | c. LENGTH OF STAY IN 1b
<u>12</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>BALTIMORE</u> 03-1 | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>1013 ST. ALBANS RD</u> | | | | | d. STREET ADDRESS
<u>1013 ST. ALBANS RD</u> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>THOMAS WALTER SOMMER</u>
First Middle Last | | | | | 4. DATE OF DEATH
<u>MAY 27 1967</u>
Month Day Year | | | | |
| 5. SEX
<u>M</u> | | 6. COLOR OR RACE
<u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>OCT. 23, 1881</u> | | 9. AGE (In years last birthday)
<u>85</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>CONCRETE FINISHER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>CONCRETE IND.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>John Battine</u>
<u>J. BATINE SOMMER</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>MAGGIE A. HERBST</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>NO</u> <u>NONE</u> | | | 16. SOCIAL SECURITY NO.
<u>216-18-0257</u> | | 17. INFORMANT
Address | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u>
<u>4201</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <u>William A. Pillsbury</u> M.D. | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| EXAMINER'S NAME (Type) <u>William A. Pillsbury</u> | | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | |
| | | | | | DEPUTY MEDICAL EXAMINER <u>Thomas A. Pillsbury</u> MD. 5-27-67
Address (Street, city, town, or county) | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF
<u>MAY 31, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>BALTIMORE CEMETERY</u> | | | 23d. LOCATION (City or Town) (County) (State)
<u>BALTIMORE, MD.</u> | | |
| 24. FUNERAL DIRECTOR
<u>John Dunn's Sons, Towson, Md.</u> | | | | | 25a. REC'D BY REGISTRAR
DATE <u>JUN 5 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |

8012

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore
c. LENGTH OF STAY IN 1b
Baltimore
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph's Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore
d. STREET ADDRESS
1419 Limit Avenue 21212
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
DARCY
First Middle Last
SPICKA | | 4. DATE OF DEATH
Month Day Year
5 23 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 16, 1967 |
| 9. AGE (In years last birthday)
7 | | 10. IF UNDER 1 YEAR
Months Days Hours Min.
7 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
Baltimore, Maryland | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
Baltimore, Maryland | |
| 13. FATHER'S NAME
Richard Spicka | | 14. MOTHER'S MAIDEN NAME
Janice Hall | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Richard Spicka | | Address
Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Interstitial pneumonia / (SDII) /
754.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Congestive heart failure
DUE TO
(c) Patent ductus arteriosus | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Interstitial pneumonia | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> or Not While <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
RUSSELL S. FISHER, M.D. | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
Address (Street, city, town, or county) | |
| 22. DATE SIGNED
5-24-67 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5-24-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
Mitchell-Wiedefeld Home, Inc.
6500 York Rd. 21212 | | 25a. REC'D BY REGISTRAR
MAY 25 1967
25b. REGISTRAR'S SIGNATURE
f Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|---|--|--|---|---|--|--|--|--|---|---|--|
| 06422 Item #16 Film #3388 5/10/67 06411 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Greater Baltimore Medical Center</u> | | | | | | d. STREET ADDRESS
<u>1557 Cottage Lane</u> | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>MARY IRENE SPONSER</u> | | | 4. DATE OF DEATH
Month Day Year
<u>May 4 1967</u> | | | 5. SEX
<u>Female</u> | | | 6. COLOR OR RACE
<u>White</u> | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH
<u>09-23-99</u> | | | 9. AGE (In years last birthday)
<u>67</u> yrs. | | | IF UNDER 1 YEAR
Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Baltimore, Md.</u> | | | |
| 13. FATHER'S NAME
<u>J Oscar Hulse</u> | | | | | | 14. MOTHER'S MAIDEN NAME
<u>Dixon, Rena</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | | | 16. SOCIAL SECURITY NO.
<u>217-28-2878</u> | | 17. INFORMANT
Address
<u>Mrs. Doris Naumann same address</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Massive pulmonary embolization</u>
172X
DUE TO (b) <u>Left femoral vein thrombosis</u>
DUE TO (c) <u>Carcinomatosis - endometrial carcinoma</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>14 mos.</u> | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (if this hospital) attended the deceased from <u>February</u> , 19 <u>66</u> , to <u>May 4</u> , 19 <u>67</u> , that (if we) last saw the deceased alive on <u>May 4</u> , 19 <u>67</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
<u>Reinhold O. Goehl, Jr.</u> | | | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22b. DATE SIGNED
<u>May 4, 1967</u> | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>R.O. GOEHL, JR., M.D.</u> | | | | | | 22d. ADDRESS
<u>6701 N. CHARLES ST., BALTO. MD 21204</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | 23b. DATE THEREOF
<u>5/8/1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Baltimore National Cem.</u> | | | 23d. LOCATION (City, town or county) (State)
<u>Baltimore, Md.</u> | | | |
| 24. FUNERAL DIRECTOR
<u>Wm J. Tubman & Sons</u> | | | | | | 25a. REC'D BY REGISTRAR
<u>Wm J. Tubman</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

0811

0811

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "THE", "AND", "OF" are faintly visible.]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06423

CERTIFICATE OF DEATH

06412

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY — | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. LENGTH OF STAY IN lb
Baltimore 21206 30.4 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | d. STREET ADDRESS
6108 Fairdel Avenue | |
| 3. NAME OF DECEASED
(Type or print) First Caryn Middle A. Last Stamm | | 4. DATE OF DEATH
Month May Day 5 Year 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2-28-67 |
| 9. AGE (In years last birthday) yrs. 2 5 Months Days Hours Min. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
Baltimore, Md. | |
| 13. FATHER'S NAME
Edward Conrad Stamm | | 14. MOTHER'S MAIDEN NAME
Jean Amato | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Mr. Edward C. Stamm | | Address
(Same) | |
| 18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aspiration pneumonia
DUE TO (b) Bacteremia
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 491X | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 5 th , 19 67 , to May 5 th , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 5 th , 19 67 , and that death occurred at 5:10 AM , from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
M. Chang | | 22b. DATE SIGNED
May 5, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) Myung Y. Chang, M.D. | | 22d. ADDRESS
7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
5/6/67. | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith Cemetery | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 | | 25a. REC'D BY REGISTRAR
DATE May 5 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | 25c. REGISTRAR'S NAME
 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

2-217831

08123

CONTRIBUTOR TO DEATH

08123

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Mr. Thomas J. Stone

John

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06424

CERTIFICATE OF DEATH

06413

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Balto. Md.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore | |
| c. LENGTH OF STAY IN Tb | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Shady Neck Nursing Home 1002 N. Rolling Rd. | | d. STREET ADDRESS
512 Charring Cross Rd. | |
| 3. NAME OF DECEASED
First Margaret Middle Staup Last Staup
(Type or print) | | 4. DATE OF DEATH
Month May Day 3 Year 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
Cauc. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Nov. 5, 1902 |
| 9. AGE (In years last birthday) yrs.
64 | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerical Work | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Balto. Co. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
late- James C. Ball | | 14. MOTHER'S MAIDEN NAME
late- Margaret A. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
218-36-6755 | |
| 17. INFORMANT
Miss Mary A. Ball | | Address
512 Charing Cross Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis
DUE TO (b) Carcinoma of the breast
DUE TO (c) 170X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH
6 months
2 months
1 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan , 19 60 , to May 3 , 1967, that (I) (we) saw the deceased alive on April 30, 1967 , and that death occurred at 5:15 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Martin L. Singewald M.D. | | 22b. DATE SIGNED
5/4/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. Martin L. Singewald | | 22d. ADDRESS
11 E. Chase St. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
May 6, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR
Witzke Funeral Dir. 4101 Edmondson Ave. | | 25a. REC'D BY REGISTRAR
DATE MAY 8 1967 | |
| 25b. REGISTRAR'S SIGNATURE
James Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00613

STATEMENT OF DEBIT

00613

Balance

Balance

Balance

Balance

Balance

512 Charles Street N.W.

Money Rock Building Room 1002 E. Holling Ave.

May 2

May 2

May 2

Nov. 5, 1903

X

Nov. 5, 1903

Balance

Balance

Balance

Balance

512 Charles Street N.W.

Money Rock Building Room 1002 E. Holling Ave.

Nov. 5, 1903

X

Balance

Balance

May 2, 1903

May 2, 1903

Balance

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06426

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film 6389 1/26/67 KK

06414

| | | | |
|--|---------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sparrows Point | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Plant Dispensary | | d. STREET ADDRESS
948 Woodlyn Road | |
| 3. NAME OF DECEASED (Type or print)
First Raymond Middle S. Last STEELEY | | 4. DATE OF DEATH
Month 5 Day 19 Year 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5-11-16 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Steel Worker | | 10b. KIND OF BUSINESS OR INDUSTRY
Steel Making | 9. AGE (In years last birthday)
51 yrs. |
| 11. BIRTHPLACE (State or foreign country)
PENNA. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
RAYMOND STEELEY | | 14. MOTHER'S MAIDEN NAME
JENNIE HORN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
YES WW II | | 16. SOCIAL SECURITY NO.
079-14-6302 | |
| 17. INFORMANT
MARGARET STEELEY | | Address
A BOVE | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
N | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
N E | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Melvin B. Davis, M.D. | | 22. DATE SIGNED
5-19-67 | |
| EXAMINER'S NAME (Type) | | 6800 Morningside Road Dundalk, Md. 21222 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/22/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | | 23d. LOCATION (City, town or county) (State)
Balto. Md | |
| 24. FUNERAL DIRECTOR
J. L. Connelly Sons | | 25a. REC'D BY REGISTRAR
DATE MAY 23 1967 | |
| ADDRESS
300 Maca | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06425

CERTIFICATE OF DEATH

06415

| | | | | | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Owings Mills
c. LENGTH OF STAY IN 1b
3 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Rosewood State Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY _____
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore
d. STREET ADDRESS
915 Stiles Street
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
Suzanne Paulette STEIN | | | | 4. DATE OF DEATH
Month Day Year
5 21 19 67 | | | | | | | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | B. DATE OF BIRTH
1-24-63 | | 9. AGE (In years lost birthday) yrs.
4 | | IF UNDER 1 YEAR
Months Days Hours Min.
_____ | | IF UNDER 24 HRS.
Hours Min.
_____ | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Dependent | | | | 10b. KIND OF BUSINESS OR INDUSTRY
none | | | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
Harry John Stein | | | | | | 14. MOTHER'S MAIDEN NAME
Eleanor Mary Cucco | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
no -- | | | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT Address
Rosewood Records, Owings Mills, Maryland | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Aspiration Pneumonia
7531 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Meningocele Congenital
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____
19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
_____ 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (this hospital attended the deceased from May 4, 1964 to May 21, 1967 , that (s) (we) lost the deceased alive on May 21, 1967 , and that death occurred at 8:25 A.M. from causes and on the date stated above. | | | | | | | | | | | | | | | |
| 22a. SIGNATURE
Richard A. Jones | | | | | | ATTENDING PHYS. <input type="checkbox"/> M.D. <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
Richard A. Jones | | | | | | 22d. ADDRESS
Rosewood State Hospital | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | 23b. DATE THEREOF
5-22-67 | | 23c. NAME OF CEMETERY OR CREMATORY
HOLY ROSARY CEM. | | 23d. LOCATION (City or Town) (County) (State)
BALTO. Co. MD. | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS
Wm. Fialkowski 2007 EASTERN AVE.
W FIALKOWSKI BALTO. MD. 21231 | | | | | | 25. RECEIVED BY REGISTRAR DATE
MAY 24 1967 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | | | |

VR A15 (4)
20 M 1/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

001130

CERTIFICATE OF DEATH

001130

4/3/4

State Hospital
Mental Hospital

Richard A. Jones
Resident of State Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06428

CERTIFICATE OF DEATH

06416

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md.
b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lutherville | | c. LENGTH OF STAY IN 1b
25 yrs. | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lutherville | | 03.1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
124 Greenridge Rd. | | d. STREET ADDRESS
124 Greenridge Rd. | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
Carl First A. Stoutenburg Middle Stoutenburg Last | | 4. DATE OF DEATH
Month May Day 1 Year 1967 | |
| 5. SEX
M | 6. COLOR OR RACE
W. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6-24-1903 |
| 9. AGE (In years last birthday)
63 yrs. | | IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
District Mgr. | | 10b. KIND OF BUSINESS OR INDUSTRY
U.S. Slicing M. Co | |
| 11. BIRTHPLACE (County & State, or foreign country)
Bloomville, N.Y. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
George Stoutenburg | | 14. MOTHER'S MAIDEN NAME
Emma Messick | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)
Yes. 1919-1922 | | 16. SOCIAL SECURITY NO.
070 03 8659 | |
| 17. INFORMANT
Mable Stoutenburg | | 124 Greenridge R.
Lutherville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY OCCLUSION
DUE TO (b) ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE
DUE TO (c) DISEASE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH
10 MIN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
DIABETES MELLITUS | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from APR 23 , 1967, to MAY 1 , 1967, that (I) (we) last saw the deceased alive on APR 23 , 1967, and that death occurred at 8:50 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
T. C. Siwinski | | 22b. DATE SIGNED
May 2, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Thaddeus C. Siwinski, M. D. | | 22d. ADDRESS
206 W. Pennsylvania Avenue (21204) | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | 23b. DATE THEREOF
May 5, 67 | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley | 23d. LOCATION (City or Town) (County) (State)
Cockeysville, Balto, Md. |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson, Towson, Md. 21204 | | 25a. REC'D BY REGISTRAR
MAY 5 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06427

CERTIFICATE OF DEATH

06417

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>—</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Randallstown</u> | | c. LENGTH OF STAY IN 1b
<u>30.4</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Balto. Co. General Hospital</u> | | d. STREET ADDRESS
<u>3703 Copley Rd.</u> | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Bernice</u> Middle <u>L.</u> Last <u>Street</u> | | 4. DATE OF DEATH
Month <u>5</u> Day <u>10</u> Year <u>1967</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>11-10-1914</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Clerk</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Social Security</u> | 11. BIRTHPLACE (County & State, or foreign country)
<u>Balto, Maryland</u> |
| 13. FATHER'S NAME
<u>Samuel G. Criss</u> | | 14. MOTHER'S MAIDEN NAME
<u>Martha L. Criss</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>219-28-5223</u> | |
| 17. INFORMANT
<u>Mr. Harold Street</u> | | Address
<u>3703 Copley Rd.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u>
DUE TO (b) <u>157X</u>
DUE TO (c) <u>0</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH
<u>months</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (1) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>66</u> , to <u>May 10</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>May 10</u> , 19 <u>67</u> , and that death occurred at <u>2:00</u> P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>David J. Miller</u> M.D. | | 22b. DATE SIGNED
<u>May 10-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>David J. Miller</u> | | 22d. ADDRESS
<u>2150 N. Rd. Owings Mills, Md.</u> | |
| 23a. BURIAL CREMATION REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>5-13-67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Arbutus Mem. Park</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Arbutus Md.</u> |
| 24. FUNERAL DIRECTOR
<u>Morton & Dyett F.H.</u> | | 25. REC'D BY REGISTRAR
<u>Charles Judge</u> | |
| 25a. ADDRESS
<u>1701 Laurens St.</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| 06423 | | 06418 | |
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Stoneleigh</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Stoneleigh</u> <u>Baltimore</u> 21212 03-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>6207 Beechwood Road</u> | | d. STREET ADDRESS
<u>6207 Beechwood Road</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>Susanna</u> First <u>M</u> Middle <u>Striebel</u> Last | | 4. DATE OF DEATH
Month <u>May</u> Day <u>4</u> Year <u>1967</u> | |
| 5. SEX
<u>female</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Nov. 30, 1877</u> |
| 9. AGE (In years last birthday)
<u>89</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Germany</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Lorenz Schiller</u> | | 14. MOTHER'S MAIDEN NAME
<u>Margaret Wehrwein</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>216-01-4166</u> | |
| 17. INFORMANT
<u>Mrs. Gretchen M. Harrison</u> | | Address
<u>same</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>a.m.</u> <u>19</u>
p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5-4</u> , 19 <u>63</u> , to <u>5-4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-4</u> , 19 <u>67</u> , and that death occurred at <u>PM</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>W. M. Smith</u> | | 22b. DATE SIGNED
<u>5-5-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>W. M. Smith</u> | | 22d. ADDRESS
<u>6305 THE ALAMEDA</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>burial</u> | 23b. DATE THEREOF
<u>5/8/67.</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Parkwood Cemetery</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Md.</u> |
| 24. FUNERAL DIRECTOR
<u>Leonard J. Ruck, Inc Baltimore, Md.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>MAY 8 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>Charles J. [Signature]</u> | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06430

CERTIFICATE OF DEATH

06419

| | | | | | | | |
|---|----------------------------------|---|-------------------------|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rosedale | | | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rosedale | | | d. STREET ADDRESS
1817 Ellinwood Road |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
1817 Ellinwood Road | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First MILDRED Middle JOSEPHINE Last STUPRICH | | | | 4. DATE OF DEATH
Month 5 Day 7 Year 1967 | | | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
4/19/15 | | 9. AGE (In years)
52 (lost birthday) yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Waitress | | 10b. KIND OF BUSINESS OR INDUSTRY
Holland House | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
Baltimore, Md. | |
| 13. FATHER'S NAME
Frank Kougl | | | | 14. MOTHER'S MAIDEN NAME
unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
217-26-7383 | | 17. INFORMANT
Oscar Stuprich, 1817 Ellinwood Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO (b) Metastatic Carcinoma of the breast / lungs & liver
DUE TO (c) Lungs & liver | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. _____ 19 67 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from June 1964 , to April 20 1967 , that (I) (we) last saw the deceased alive on April 20 1967 , and that death occurred at 10 A.M. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Dr. John Geldrich | | | | 22b. DATE SIGNED
May 9/1967 | | 22c. PHYSICIAN'S NAME (Type)
Dr. John Geldrich | |
| 22d. ADDRESS
8019 Philadelphia Road | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/11/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith Cem | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | |
| 24. FUNERAL HOME
Schimunek Funeral Home, Inc.
3331 Brehms Lane | | | | 25a. REC'D BY REGISTRAR
MAY 11 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CENTRAL INTELLIGENCE AGENCY

NOV 11 1950

TO DIRECTOR, CIA

FROM SAC, NEW YORK

SUBJECT

JOSEPH P. KATZ

RE: KATZ, JOSEPH P.

RE: KATZ, JOSEPH P.

RE: KATZ, JOSEPH P.

RE: KATZ, JOSEPH P.

RE: KATZ, JOSEPH P.

RE: KATZ, JOSEPH P.

RE: KATZ, JOSEPH P.

JOSEPH P. KATZ

JOSEPH P. KATZ

JOSEPH P. KATZ

JOSEPH P. KATZ

JOSEPH P. KATZ

JOSEPH P. KATZ

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06431

CERTIFICATE OF DEATH

06420

| | | | |
|---|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Josephs Hospital | | d. STREET ADDRESS
1912 E. Madison Street | |
| 3. NAME OF DECEASED
(Type or print)
First Emma Middle M Last SUPIK | | 4. DATE OF DEATH
Month May Day 28 Year 1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12-22-08 |
| 9. AGE (In years last birthday)
58 | | 10. IF UNDER 1 YEAR
Months 5 Days 12 Hours 15 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY
Social Security Agency | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Charles A. Supik | | 14. MOTHER'S MAIDEN NAME
Emma H. Kozlovsky | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
215-10-8473 | |
| 17. INFORMANT
Edward Supik, brother | | Address
Box 67 Route 1, | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute hemorrhagic pancreatitis.
5890 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that 4 (this hospital) attended the deceased from May 27 , 19 67 , to May 28 , 19 67 , that it (we) last saw the deceased alive on May 28 , 19 67 , and that death occurred at 7:10 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Juana S. Cockburn | | 22b. DATE SIGNED
May 29, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Juana S. Cockburn, M.D. | | 22d. ADDRESS
7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
6/1/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Balto., Md. | |
| 24. FUNERAL DIRECTOR
Schimunek Funeral Home | | 25a. REC'D BY REGISTRAR
JUN 1 1967 | |
| 25b. REGISTRAR'S SIGNATURE
J. Schimunek | | | |

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|--|-------------------------------|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland | | b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Parkville | | c. LENGTH OF STAY IN 1b
22 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Balto. 21234 Parkville | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
99 8801 Harford Road St. Joseph's Hosp. | | d. STREET ADDRESS
8801 Harford Rd. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Rt. Rev. William J. Sweeney | | First Middle Last | | 4. DATE OF DEATH
Month May Day 12 Year 1967 | |
| 5. SEX
M. | 6. COLOR OR RACE
W. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 5 1901 | | 9. AGE (In years last birthday)
66 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Priest | | 10b. KIND OF BUSINESS OR INDUSTRY
Religious | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore Maryland | |
| 13. FATHER'S NAME
Dennis Sweeney | | 12. CITIZEN OF WHAT COUNTRY?
USA | | 14. MOTHER'S MAIDEN NAME
Mary Brennan | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Family Records. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4201 Congestive heart failure
DUE TO & Cardiac asthma
(b) Arteriosclerotic Cardiovascular Disease
DUE TO with Coronary Artery Disease
(c) 15-20 yrs | | INTERVAL BETWEEN ONSET AND DEATH
30-45 Mins | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
2 Old Myocardial Infarction | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Nat While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
Vicente P. Ang | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
May 13, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
VICENTE P. ANG | | 22d. ADDRESS
St. Joseph Hospital | | | |
| 23a. BURIAL, CREMATION, REBURY
BURIAL | | 23b. DATE THEREOF
5-17-1967 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | |
| 23d. LOCATION (City or town)
Baltimore Md. | | | | | |
| 24. FUNERAL DIRECTOR
C. F. Evans & Son 8802 Harford Rd. | | 25a. REC'D BY REGISTRAR
DATE MAY 18 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Approved: Frank G. Xasik MD 5/12/67 Post-Doctoral
Medical Examiner

MEDICAL CERTIFICATION

VR A15 (4)
20 M 1/66

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06433

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06422

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Balto.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Alleg.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland, Md.</u> | |
| c. LENGTH OF STAY IN 1b <u>5 yrs.</u> | | d. STREET ADDRESS <u>12 Virginia Ave.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rosewood State Hosp.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>LELAND EDWARD SWICK</u> | | 4. DATE OF DEATH <u>5 26 19 67</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-11-55</u> |
| 9. AGE (In years last birthday) <u>12</u> yrs. | | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dependent</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Allegany Co., Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Richard Lee Swick</u> | | 14. MOTHER'S MAIDEN NAME <u>Mildred Elizabeth Moss</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>none</u> | |
| 17. INFORMANT <u>Rosewood Records, Owings Mills, Maryland</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Asphyxia due to aspiration of cookie</u>
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>9217</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>25 min.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>Severe Mental Retardation with hyperactivity</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Stuffed cookie in mouth and choked on cookie</u> | |
| 20c. TIME OF INJURY Month, Day, Year
<u>12:30 5-26-1967</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Holland Cottage</u> | 20f. (City or town) (County) (State)
<u>Owings Mills, Balto., Md.</u> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>D. D. Caples</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>D. D. Caples, M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | Address (Street, city, town, or county) <u>5-26-67</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>5/29/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memo. Pk.</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Cumberland, Allegany, Md.</u> |
| 24. FUNERAL DIRECTOR <u>Philip B. Wendt 121 Mem. Ave., Cumb., Md.</u> | | 25a. REC'D BY REGISTRAR <u>MAY 31 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>William J. Sledge</u> | |

THE NEW YORK PUBLIC LIBRARY
ASTOR LENOX TILDEN FOUNDATION
500 5TH AVENUE NEW YORK 17, N.Y.

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500 5TH AVENUE NEW YORK 17, N.Y.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06434

06423

| | | | |
|---|-------------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Summit Nursing Home | | d. STREET ADDRESS
2683 West Park Drive 21207 | |
| 3. NAME OF DECEASED (Type or print)
First Blanche Middle Talbott Last Talbott | | 4. DATE OF DEATH
Month May Day 16 Year 1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9/14/95 |
| 9. AGE (In years last birthday)
71 yrs. | | 10. IF UNDER 1 YEAR
Months 20 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Row | | 14. MOTHER'S MAIDEN NAME
Susan | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
None | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Mrs. Florence A. Stump | | Address Lane 21229 710 N. Chapelgate | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive CARDIOVASCULAR Disease
443X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Essential Hypertension DUE TO
(c) unKnown | | | INTERVAL BETWEEN ONSET AND DEATH
at least 20 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from February 27, 1967 , to MAY 16, 1967 , that (I) (we) last saw the deceased alive on MAY 14, 1967 , and that death occurred at 8:20 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Melvin N Borden | | 22b. DATE SIGNED
5/16/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Melvin Borden WI 5-6680 | | 22d. ADDRESS
5000 BALTO NATIONAL PIKE 21229 600 N. Chapel Gate Lane | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
5/19/67 | 23c. NAME OF CEMETERY OR CREMATORY
Western Cemetery | |
| 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | 23e. REC'D BY REGISTRAR
MAY 18 1967 | |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY _____ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | c. LENGTH OF STAY IN 1b
83 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | e. STREET ADDRESS
1313 WEST MULBERRY STREET | |
| 3. NAME OF DECEASED (Type or print)
First WILLIAM Middle NMI Last TAILEY | | 4. DATE OF DEATH
Month MAY Day 27 Year 19 67 | |
| 5. SEX
MALE | 6. COLOR OR RACE
NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8/18/95 |
| 9. AGE (In years last birthday) yrs. 71 | | 10. IF UNDER 1 YEAR
Months _____ Days _____ Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABORER | | 10b. KIND OF BUSINESS OR INDUSTRY
CONSTRUCTION | |
| 11. BIRTHPLACE (County & State, or foreign country)
CULPEPPER, VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
GEORGE TAILEY | | 14. MOTHER'S MAIDEN NAME
BELLE PARKER | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WWI | | 16. SOCIAL SECURITY NO.
218 05 78 89 | |
| 17. INFORMANT
CLINICAL RECORDS, VAH, FT. HOWARD, MD. | | Address _____ | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CHRONIC HEART FAILURE
DUE TO 4200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) AFTERIOSCLEROSIS HEART DISEASE
DUE TO _____
(c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH
UNKNOWN
YEARS _____ |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a.m. Month 19 Year 19
p.m. _____ | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that he (this hospital) attended the deceased from MARCH 5, 1967 , to MAY 27, 1967 , that he (we) last saw the deceased alive on MAY 27, 1967 , and that death occurred at 8:50 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
ZUI-SUN TAO | | 22b. DATE SIGNED
5/27/67 | |
| 22c. PHYSICIAN'S NAME (Type)
ZUI-SUN TAO, M.D. | | 22d. ADDRESS
VAH, FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
5/31/67 | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL CEMETERY BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR
ADOLPHUS HALSTEAD FUNERAL HOME | | 25a. REC'D BY REGISTRAR
DATE MAY 29 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06436

06425

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
6001 UPDALE COURT | | d. STREET ADDRESS
6001 UPDALE COURT | |
| 3. NAME OF DECEASED
(Type or print) MARTIN TANNER | | 4. DATE OF DEATH MAY 14, 1967 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/25/1892 |
| 9. AGE (In years last birthday) 74 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED-RAILROAD | | 11b. KIND OF BUSINESS OR INDUSTRY
ATLANTIC COAST LINE | |
| 12. BIRTHPLACE (County & State, or foreign country)
BROOKLYN, NEW YORK | | 13. CITIZEN OF WHAT COUNTRY?
USA | |
| 14. FATHER'S NAME
HENRY TANNER | | 15. MOTHER'S MAIDEN NAME
SARAH GELLER | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES ARMY WW 1 | | 17. SOCIAL SECURITY NO. 718-12-1116 | |
| 18. INFORMANT MRS. SYBIL TANNER WHITE | | Address 6001 UPDALE COURT | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction
DUE TO Arteriosclerotic cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. with prior myocardial infarction Jan 67
(b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH
1 hr
6 mos | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 21. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 22d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work | 22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 22f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Oct 1963 , to May 17, 1967 that (I) (we) last saw the deceased alive on May 12 1967 , and that death occurred at 10P M , from causes and on the date stated above. | | | |
| 22a. SIGNATURE DR. MARVIN DAVIS | | 22b. DATE SIGNED MAY 15, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) DR. MARVIN DAVIS | | 22d. ADDRESS 6512 LIBERTY ROAD | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
5/16/67 | 23c. NAME OF CEMETERY OR CREMATORY
HEBREW FRIENDSHIP | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND |
| 24. FUNERAL DIRECTOR
SOL LEVINSON & BROS. INC., 6010 REIST., RD. | | 25a. REC'D BY REGISTRAR
MAY 19 1967 | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge |

2352

2500

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06437

06426

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
e. COUNTY <u>Baltimore Co.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
e. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>PARKTON</u> | | | | c. LENGTH OF STAY IN 1b
<u>Life</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>RFD #1</u> | | | | d. STREET ADDRESS
<u>RFD #1</u> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>SARAH Elsie Thompson</u> | | | | 4. DATE OF DEATH <u>MAY 26</u> 19 <u>67</u> | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>Cau.</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>6-22-1885</u> | |
| 9. AGE (in years last birthday)
<u>81</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 11. BIRTHPLACE (State or foreign country)
<u>BALTO. Co. MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Home</u> | | | |
| 13. FATHER'S NAME
<u>Joshua Wheeler</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Rachel Hare</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>NO</u> | | | | 16. SOCIAL SECURITY NO.
<u>219-30-83580</u> | | 17. INFORMANT
<u>Mrs. Ethel R. Price</u> Address <u>149 Liberty St. Westminster, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>U.S.C.V. disease</u>
4221
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, }
DUE TO (b)
DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>A. M. France</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>A. M. FRANCE</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | Address (Street, city, town, or county) <u>PARKTON, MD</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>May 29, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>MT. CARMEL Cemetery</u> | | 23d. LOCATION (City, town or county) (State)
<u>PARKTON Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>John E. Loff</u> | | | | 25a. REC'D BY REGISTRAR
<u>Charles Judge</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |
| ADDRESS
<u>Hampstead, Md.</u> | | | | DATE
<u>MAY 31 1967</u> | | | |

00130

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00130

FOR STATE
HEALTH DEPT.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #8 & 9 Film #G389 5/29/67 pc

06438

CERTIFICATE OF DEATH

06427

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Parkville | | c. LENGTH OF STAY IN TOWN | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
2910 Onyx Road | | d. STREET ADDRESS
2910 Onyx Road | |
| 3. NAME OF DECEASED (Type or print)
First RANDOLPH Middle H. Last THRASHER, SR. | | 4. DATE OF DEATH
Month May Day 19 Year 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1906
October 5, 1907 |
| 9. AGE (In years last birthday)
60 | | 10. IF UNDER 1 YEAR
Months 6 Days 05 Hours 59 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Letter Carrier Post Office | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
William Thrasher | | 14. MOTHER'S MAIDEN NAME
Eleanor Simmons | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
Unk. | |
| 17. INFORMANT
Mrs. Verna L. Thrasher | | Address
(Same) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease
H200
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
none | | INTERVAL BETWEEN ONSET AND DEATH
13 yrs | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 3. 23 , 19 54 , to 5. 19 , 19 67 , that (I) (we) last saw the deceased alive on 5. 4 , 19 67 , and that death occurred at 4 P M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
DR. JOS. SIKLOVEN | | 22b. DATE SIGNED
5. 20. 67 | |
| 22c. PHYSICIAN'S NAME (Type)
DR. JOS. SIKLOVEN | | 22d. ADDRESS
7122 Harford Rd Baltimore | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/23/67. | |
| 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 | | 25a. REC'D BY REGISTRAR
DATE MAY 22 1967 | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | 25c. REGISTRAR'S NAME
[Signature] | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06433

CERTIFICATE OF DEATH

06428

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|--|----------------------------------|---|---|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Baltimore County General Hospital.</u> | | | | d. STREET ADDRESS
<u>1523 Kirkwood Rd.</u> | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Eva</u> Middle <u>F.</u> Last <u>Wilen</u> | | | | 4. DATE OF DEATH
Month <u>5</u> Day <u>29</u> Year <u>1967</u> | | | |
| 5. SEX
<u>F.</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>1-6-95</u> | 9. AGE (In years lost birthday)
<u>72</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Balt., Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> |
| 13. FATHER'S NAME
<u>Charles Koeneke</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Katherine Dreschler</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Mrs. Lena Koerber</u>
<u>1521 Clairidge Rd. - 21207</u> | | Address |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Pulmonary Fibrosis</u>
DUE TO
(c) <u>Pulmonary Emphysema</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5-19</u> , 19 <u>67</u> , to <u>5-29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-19</u> , 19 <u>67</u> , and that death occurred at <u>2:45</u> M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>[Signature]</u> | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
<u>5-29/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Stephen Lai</u> | | | | 22d. ADDRESS
<u>Balto. Co. Hosp., Old Court Rd.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>6/1/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Baltimore National</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>Witzke F. D. - 4101 Edmondson Ave.</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>MAY 31 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CONFIDENTIAL

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VR A15 (4)
15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|-------------------------------------|---|---|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 06440 | | | | | 06429 | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | |
| a. COUNTY
<i>Baltimore</i> | | | MARYLAND | | a. STATE
<i>Maryland</i> | | b. COUNTY
<i>Baltimore</i> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Baltimore</i> | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Baltimore</i> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<i>131 Elinor Avenue</i> | | | | | d. STREET ADDRESS
<i>131 Elinor Ave.-21236</i> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
<i>Edward F. Tilling Sr.</i> | | | First Middle Last | | 4. DATE OF DEATH
<i>May 10 19 67</i> | | Month Day Year | | |
| 5. SEX
<i>Male</i> | | 6. COLOR OR RACE
<i>White</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>12-28-1900</i> | | 9. AGE (in years last birthday)
<i>66</i> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Foreman-Water Meter repair</i> | | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>Balto. City</i> | | 11. BIRTHPLACE (County & State, or foreign country)
<i>Ilchester, Md.</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | |
| 13. FATHER'S NAME
<i>Joseph V. Tilling</i> | | | | | 14. MOTHER'S MAIDEN NAME
<i>Lulu Marie Hanes</i> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<i>No</i> | | | 16. SOCIAL SECURITY NO.
<i>214-20-3426</i> | | 17. INFORMANT
<i>Mary (Marie) C. Tilling-131 Elinor Ave.</i> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebral aneurysm</i>
1621
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <i>Bronchogenic carcinoma</i>
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<i>ACVD & known Atrial fibrillation.</i> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<i>months.</i>
<i>2 yrs?</i> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
<i>19</i> | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>June</i> , 1967, to <i>10 May</i> , 1967, that (I) (we) last saw the deceased alive on <i>9 May</i> 1967, and that death occurred at <i>2:30</i> M, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<i>John C. Hyde</i> | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<i>5-11-67</i> | | |
| 22c. PHYSICIAN'S NAME (Type)
<i>JOHN C. Hyde</i> | | | | | 22d. ADDRESS
<i>7527 Belair Rd Baltimore</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE THEREOF
<i>5-13-67</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Holy Redeemer Cemetery</i> | | 23d. LOCATION (City, town or county) (State)
<i>Baltimore, Maryland</i> | | | |
| 24. FUNERAL DIRECTOR
<i>John C. Miller Inc.-6415 Belair Rd.-21206</i> | | | | | 25a. REC'D BY REGISTRAR
<i>MAY 15 1967</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|---|--|-----------------------------------|---|---|---|----------------------------------|--|---|--|---|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | |
| 06441 | | | | | 06430 | | | | | | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | | | | | | |
| a. COUNTY
Baltimore | | | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
1 Week | | | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
House In The Pines Fussing Ave. | | | | | | |
| a. STATE
Md. | | | b. COUNTY
Baltimore | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Baltimore | | | d. STREET ADDRESS
307 S. Augusta Ave. | | | | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
Elmira M. Travers | | | | | 4. DATE OF DEATH
May 26, 1967 | | | | | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
July 2, 1878 | | 9. AGE (In years last birthday)
88 yrs. | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House Wife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Balto. Md. | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | | | | |
| 13. FATHER'S NAME
George Aaron | | | | | 14. MOTHER'S MAIDEN NAME
Amelia Kriel | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | | | | 16. SOCIAL SECURITY NO. | | | | | 17. INFIRMANT
Mrs. Margaret G. Banks 307 S. Augusta Ave. | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
4221 Cerebral Hemorrhage
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Atherosclerotic CV Disease
DUE TO
(c) | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 wk.
2 yr. | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.
19 | | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | |
| 20f. (City or town) (County) (State) | | | | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 4/1, 1958, to 5-26, 1967, that (I) (we) last saw the deceased alive on 5-26, 1967, and that death occurred at 12:20 PM, from the causes and on the date stated above. | | | | | | | | | | | | | | |
| 22a. SIGNATURE
John F. Schaefer | | | | | 22b. DATE SIGNED
5/28/67 | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | 22d. ADDRESS | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | 23b. DATE THEREOF
May 29, 1967 | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cem. | | | | |
| 23d. LOCATION (City, town or county) (State)
Balto. Md. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
G. Truman Schwab 3512 Frederick Ave, Balto. Md. | | | | | 25a. REC'D BY REGISTRAR
DATE MAY 31 1967 | | | | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | | |

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[Faint, illegible text and markings covering the page]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06442

CERTIFICATE OF DEATH

06431

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
4314 Barrington Ave. | | d. STREET ADDRESS
4314 Barrington Rd. 21229 | |
| 3. NAME OF DECEASED (Type or print)
First Jay Middle H. Last Treiber | | 4. DATE OF DEATH
Month May Day 21 Year 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7/11/99 |
| 9. AGE (In years lost birthday)
67 yrs. | | 10. UNDER 1 YEAR
Months 67 Days 67 Hours 67 Min. | 11. CITIZEN OF WHAT COUNTRY?
USA |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Electrician - Ret. | | 10b. KIND OF BUSINESS OR INDUSTRY
Western Union | |
| 11. BIRTHPLACE (County & State, or foreign country)
Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Herbert Treiber | | 14. MOTHER'S MAIDEN NAME
Elizabeth Sheely | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
215-03-7490 | |
| 17. INFORMANT
Mrs. Helen I. Treiber | | Address
4314 Barrington Rd. 21229 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute pulmonary edema
4221 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Pulmonary emphysema DUE TO
(c) A.S.C.V. disease | | | INTERVAL BETWEEN ONSET AND DEATH
3 hours
5 years
? |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. 19
p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from March , 19 62 to May 21 , 19 67 , that (I) (we) last saw the deceased alive on May 20 , 19 67 , and that death occurred at 6 A.M. , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
D. C. MacLaughlin | | 22b. DATE SIGNED
5/22/67 | |
| 22c. PHYSICIAN'S NAME (Type)
D. C. MacLaughlin | | 22d. ADDRESS
303 N. Rolling Rd. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
5/24/67 | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Cemetery | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard | | 25a. REC'D BY REGISTRAR
MAY 25 1967 | |
| 24b. ADDRESS
4107 Wilkens Ave. | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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STATE OF TEXAS

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County of ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|---|--|-----------------------------------|--|---|---|------------------------------|-----------|----------------------------------|--|
| 06443 | | | | | 06432 | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) | | | | |
| a. COUNTY | | Baltimore | | | a. STATE | | Maryland | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | Catonsville | | | b. COUNTY | | Baltimore | | |
| c. LENGTH OF STAY IN 1b | | 32yr10mth3dys | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | Baltimore | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | | d. STREET ADDRESS | | | | |
| SPRING GROVE STATE HOSPITAL | | | | | 1819 East 29th Street | | | | |
| 3. NAME OF DECEASED (Type or print) | | | | | e. IS RESIDENCE ON A FARM? | | | | |
| First Middle Last | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| WILLIAM Kerr TURNER | | | | | May 21 1967 | | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | |
| male | | white | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Oct. 28, 1909 | | 57 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | IF UNDER 1 YEAR IF UNDER 24 HRS. | |
| laborer | | factory | | Maryland | | U. S. | | Months Days Hours Min. | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | |
| ? Koester | | | | | Kate Morgan | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | | 16. SOCIAL SECURITY NO. | | | | |
| No | | | | | None | | | | |
| 17. INFORMANT | | | | | Address | | | | |
| Records: SPRING GROVE STATE HOSPITAL | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO LATE COMPLICATION FOLLOWING SURGERY | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> ND <input type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | | | | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | | | |
| 20f. (City or town) (County) (State) | | | | | | | | | |
| 21. I certify that (this hospital) attended the deceased from July 19, 1934, to MAY 21, 1967, that (we) last saw the deceased alive on MAY 21, 1967, and that death occurred at 2:00 P.M. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE George A. Rodon | | | | | | | | | |
| 22b. DATE SIGNED 5-21-67 | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) George A. Rodon | | | | | | | | | |
| 22d. ADDRESS SPRING GROVE ST HOSP. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | | | |
| 23b. DATE THEREOF 5/24/67. | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery | | | | | | | | | |
| 23d. LOCATION (City, town or county) (State) Baltimore, Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214 | | | | | | | | | |
| 25a. REC'D BY REGISTRAR MAY 24 1967 | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | | | | | | | |

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Washington, D.C.

John F. Kennedy Library

Records

Serial

MAY 2 1967

Edward J. Black, Inc. 21214

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

06444

06433

| | | | | | | | |
|--|------------------------------|--|---|---|--------------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTO</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>ESSEX</u> | | | c. LENGTH OF STAY IN 1b | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>ESSEX</u> <u>13-1</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>FRANKLYN AVE. UHL</u> | | | | d. STREET ADDRESS
<u>528 FRANKLYN AVE</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
<u>528 FRANKLYN AVE</u> First Middle Last
<u>George Wm. Uhl</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>MAY 29 1967</u> | | | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>MAY 30 1893</u> | | 9. AGE (In years lost birthday)
<u>73</u> yrs. | 10. IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>BARBER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>MD.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>ADAM UHL</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>MARY BOHL</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>UNK</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>LILLIAN UHL</u> | | Address
<u>ABOVE</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u>
<u>4201</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
<u>Theo C. Patterson</u> | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22. DATE SIGNED
<u>5/29/67</u> | |
| EXAMINER'S NAME (Type) | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | Address (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>6/1/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>SACRED HEART</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>BALTO. MD.</u> | |
| 24. FUNERAL DIRECTOR
<u>JG CONNELLY</u> | | ADDRESS
<u>300 MACE</u> | | 25a. REC'D BY REGISTRAR
<u>JUN 1 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 shall be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06445

06434

| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills
c. LENGTH OF STAY IN 1b 49 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Timber Grove Road | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills
d. STREET ADDRESS Timber Grove Road
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Lucy Lee Utz | | 4. DATE OF DEATH May 1, 1967 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 21, 1889 |
| 9. AGE (In years last birthday) 77 yrs. | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY --- | |
| 11. BIRTHPLACE (County & State, or foreign country) Madison Co., Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Carpenter | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 217-48-4993 | |
| 17. INFORMANT Mrs. Evelyn A. Ebaugh | | Address 726 Penna. Ave. Westminster, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4221 Uremia
DUE TO (b) Arterio sclerotic C.V. Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Partial paralysis rt. arm & leg.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
Partial paralysis rt. arm & leg. | | | INTERVAL BETWEEN ONSET OF DEATH 24 hrs.
years |
| 20a. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from April 28, 1967 to May 1, 1967 , that (I) (we) last saw the deceased alive on April 30, 1967 , and that death occurred at 11:00 M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Martin E. Strobel | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Martin E. Strobel | | 22d. ADDRESS Reisterstown, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF May 4, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY All Saints Cemetery | | 23d. LOCATION (City, town or county) (State) Reisterstown, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE A. J. Eckhardt | | 25a. REC'D BY REGISTRAR MAY 4 1967 | |
| ADDRESS Owings Mills, Md. | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06446

CERTIFICATE OF DEATH

06435

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
30.4 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
House In The Pines | | d. STREET ADDRESS
2833 Frederick Ave. 21223 | |
| 3. NAME OF DECEASED (Type or print)
First HENRY Middle C. Last VELTEN | | 4. DATE OF DEATH
Month May Day 8 Year 19 67 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3/14/88 |
| 9. AGE (In years last birthday)
79 | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | 11. IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Motorman - retired | | 10b. KIND OF BUSINESS OR INDUSTRY
Balto. Transit | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John H. Veltan | | 14. MOTHER'S MAIDEN NAME
Wilamena Lentz | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE FAILURE
1810 DUE TO BRONCHOPNEUMONIA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) DUE TO CHRONIC URINARY TRACT INFECTION
(c) CARCINOMA URINARY BLADDER | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 3-11 , 19 67 , to 5-8 , 19 67 , that (I) (we) lost saw the deceased alive on 5-8 , 19 67 , and that death occurred at 11:20 P.M. , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
D. Sorongon | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) DOMINGO C. SORONGON M.D. | | 22d. ADDRESS 3915 HOLLINS FERRY RD, BALTIMORE, MD. 21227 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
5/12/67 | 23c. NAME OF CEMETERY OR CREMATORY
Western Cemetery | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard | | 25a. REC'D BY REGISTRAR
4107 Wilkens Ave. 21229 | |
| 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | DATE MAY 10 1967 | |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

7 1
FOR STATE
HEALTH DEPT.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---------------------------|--|---|--|--|--|---|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 3, MARYLAND | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 06447 06436 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Md</u> b. COUNTY <u>Balto</u> | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Balto</u> | | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Balto Md</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4205 Silver Spring Rd</u> | | | | | | d. STREET ADDRESS <u>4205 Silver Spring</u> | | | | | |
| 3. NAME OF DECEASED
(Type or print) <u>James Holden Vetter</u> | | | | | | 4. DATE OF DEATH <u>May 28 1967</u> | | | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>11/25/02</u> | | 9. AGE (In years, if UNDER 1 YEAR; if UNDER 24 HRS. last birthday) <u>64</u> Months Days Hours Min. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gambler (Retired 7-8 yrs)</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u> | | | | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>John Vetter</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Olive Payne</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | | | 16. SOCIAL SECURITY NO. <u>214-01-9409</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Artery Occlusion</u>
4201 DUE TO <u>Coronary Artery Disease</u>
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO <u>Atherosclerotic Cardiovascular Disease</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) | | | | 20g. (County) | | | | 20h. (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>F. T. KASIK JR.</u> | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county) <u>9005 Hopwood Rd</u> | | | | | |
| EXAMINER'S NAME (Type) <u>F. T. KASIK JR.</u> | | | | | | DATE SIGNED <u>5/28/67</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>5/31/67</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cem.</u> | | | | 22d. LOCATION (City, town, or country) <u>Balto., Md.</u> (State) | |
| 23. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto., Md.</u> ADDRESS | | | | | | 24a. REC'D BY REGISTRAR <u>Charles Judge</u> 24b. REGISTRAR'S SIGNATURE
DATE <u>MAY 31 1967</u> | | | | | |

Olive Tamm

John Vetter

Baltimore, Md.

Baltimore, Md.

Baltimore, Md.

Baltimore, Md.

Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06448

CERTIFICATE OF DEATH

06437

| | | | | | | | |
|--|--|---|-------------------------|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Anneslie</u> | | | c. LENGTH OF STAY IN 1b | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Anneslie</u> 03-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>608 Windwood Road</u> | | | | d. STREET ADDRESS
<u>608 Windwood Rd.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Leonette</u> Middle <u>Hogan</u> Last <u>Voelker</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>10</u> Year <u>1967</u> | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH
<u>April 11, 1903</u> 64 yrs. | |
| 9. AGE (In years last birthday)
<u>64</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Personnel Officer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Balto. Life Ins. Co.</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13. FATHER'S NAME
<u>James A. Hogan</u> | | 14. MOTHER'S MAIDEN NAME
<u>Cecelia Hoffman</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>214-18-9185</u> | | 17. INFORMANT
Address <u>Mrs. Patricia L. Peroutka</u> <u>Same</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Melanotic carcinoma</u>
157X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>(pancreatic?)</u>
DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>18 mos.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 .
p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>December, 1962</u> to <u>May 10, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 7, 1967</u> , and that death occurred at <u>8 P.M.</u> from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Carlton L. Sexton</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>May 11, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Dr. Carlton Sexton</u> | | | | 22d. ADDRESS
<u>819 Park Ave. Balto., Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF
<u>5-12-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Parkwood</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Maryland</u> | |
| 24. FUNERAL DIRECTOR
<u>Mitchell-Wiedefeld Home, Inc.</u>
<u>6500 York Rd. Baltimore, Md. 21212</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>MAY 12 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

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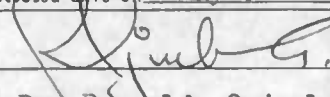
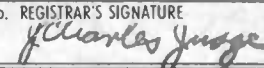
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. LENGTH OF STAY IN 1b
7 Months | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
58 St. Joseph Hospital | | d. STREET ADDRESS
216 Eastspring Rd. 21093 | |
| 3. NAME OF DECEASED (Type or print)
First Louis Middle J. Last Voluz | | 4. DATE OF DEATH
Month May Day 6 Year 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2/22/82 |
| 9. AGE (In years last birthday)
85 yrs. | | 10. IF UNDER 1 YEAR
Months 6 Days 5 Hours 5 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
Walter | |
| 11. BIRTHPLACE (County & State, or foreign country)
Switzerland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Joseph Voluz | | 14. MOTHER'S MAIDEN NAME
Angeline Gaillard | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
064 03 7764 | |
| 17. INFORMANT
Hospital Records | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral Pyonephrosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prostatic Hypertrophy
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Renal Cell Carcinoma | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) - (County) (State) | |
| 21. I certify that Dr. (this hospital) attended the deceased from April 27 , 19 67 , to May 6 , 19 67 , that (I) (we) last saw the deceased alive on May 6 , 19 67 , and that death occurred at 10:20pm from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
 | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. Reynaldo Orjuela-Gomez | | 22d. ADDRESS
7620 York Rd., Baltimore, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5-11-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Mt St. Marys | | 23d. LOCATION (City or Town) (County) (State)
Flushing N.Y. | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson, Towson, Md. | | 25a. REC'D BY REGISTRAR
MAY 10 1967 | |
| 25b. REGISTRAR'S SIGNATURE
 | | | |

4530

62130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|--|--|--|---|---|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 06450 | | | | | 06439 | | | | |
| 1. PLACE OF DEATH
e. COUNTY <u>Baltimore</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>
c. LENGTH OF STAY IN 1b <u>6 days</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>House In The Pines</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE <u>md</u>
b. COUNTY <u>✓</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>
d. STREET ADDRESS <u>2153 Sidney Ave</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Edward E.</u> Middle <u>Wahl</u> Last <u>Wahl</u> | | | | | 4. DATE OF DEATH
Month <u>5</u> Day <u>19</u> Year <u>1967</u> | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>3/2/1910</u> | | 9. AGE (In years last birthday) <u>57</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Glass Cutter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Glass Co.</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>Ernest E. Wahl</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Lillian M. Gontum</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service) | | | | | 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT <u>Mr Francis Coleman Wahl</u> Address <u>above</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic Ca of Brain</u>
1621 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Primary Ca of Lung.</u>
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>32nd</u>
<u>23rd</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5-3-</u> 1967 to <u>5-9-</u> 1967, that (I) (we) last saw the deceased alive on <u>5-8-</u> 1967, and that death occurred at <u>2:45 PM</u> from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <u>Wilmer K. Gallagher</u> M.D. | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>5/9/67</u> | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher, M.D.</u> | | | | | 22d. ADDRESS <u>6209 Frederick Ave. Baltimore 21228, Md.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>5/10/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Green Haven Cem.</u> | | 23d. LOCATION (City, town or county) (State) <u>Pitchee Hwy Md.</u> | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan & Son Inc</u> ADDRESS <u>23, Md.</u> | | | | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>MAY 12 1967</u> | | 25b. REGISTRAR'S SIGNATURE | | |

40330

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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06451

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06440

| | | | | | | | |
|--|----------------------------------|---|--|---|---|---|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | | | c. LENGTH OF STAY IN 1b
2 DAYS | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | | | d. STREET ADDRESS
721 NORTH FREMONT AVENUE | | | |
| 3. NAME OF DECEASED (Type or print)
First THOMAS Middle ISAAC Last WALLACE | | | | 4. DATE OF DEATH
Month MAY Day 22 Year 19 67 | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
JUNE 18, 1893 | | 9. AGE (In years last birthday)
73 yrs. | IF UNDER 1 YEAR
Months | IF UNDER 24 HRS.
Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
DISPLAYER | | 10b. KIND OF BUSINESS OR INDUSTRY
DEPARTMENT STORE | | 11. BIRTHPLACE (County & State, or foreign country)
CALVERT COUNTY, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
WILLIAM H. WALLACE | | | | 14. MOTHER'S MAIDEN NAME
AMELIA E. COOKE | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW-1 | | 16. SOCIAL SECURITY NO.
212 09 90 56 | | 17. INFORMANT
CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
4201
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
RECENT | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 20 , 19 67 , to May 22 , 19 67 , that (I) (we) last saw the deceased alive on MAY 22 , 19 67 , and that death occurred at 12:45 a. M. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>Howard C. Kramer</i> | | | | 22b. DATE SIGNED
5/22/67 | | 22c. PHYSICIAN'S NAME (Type)
HOWARD C. KRAMER, M. D. | |
| 22d. ADDRESS
VAH FORT HOWARD, MARYLAND | | | | 22e. ADDRESS
VAH FORT HOWARD, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
5-24-67 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR
ELROY O WILSON FUNERAL HOME | | | | 25a. REC'D BY REGISTRAR
DATE MAY 23 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06452

CERTIFICATE OF DEATH

06441

| | | | | | |
|---|--|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | | c. LENGTH OF STAY IN TB
129 Days | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Veterans Administration Hospital | | | d. STREET ADDRESS
2925 E. Baltimore Street | | |
| 3. NAME OF DECEASED (Type or print)
First WILLIAM Middle JOHN Last WALTON | | | 4. DATE OF DEATH
Month MAY Day 28 Year 19 67 | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9/5/91 | 9. AGE (In years last birthday)
75 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machine Nail Helper | | | 10b. KIND OF BUSINESS OR INDUSTRY
Steel | | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore County, Maryland | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
William T. Walton | | | 14. MOTHER'S MAIDEN NAME
Florence Fuller | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WW I | | | 16. SOCIAL SECURITY NO.
213-09-15-71 | | |
| 17. INFORMANT
Clin. Rec. VA Hospital, Fort Howard, Md. | | | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA
DUE TO (b) DIABETES MELLITUS
DUE TO (c) LESS THAN 10 DAYS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | INTERVAL BETWEEN ONSET AND DEATH
YEARS |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
PERIPHERAL VASCULAR INSUFFICIENCY | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 19 o.m. p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | |
| 21. I certify that xx (this hospital) attended the deceased from January 19, 19 67 , to May 28, 19 67 , that xx (we) last saw the deceased alive on May 28, 19 67 , and that death occurred at 5:50AM from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
John W. Payne | | | 22b. DATE SIGNED
5/28/67 | | |
| 22c. PHYSICIAN'S NAME (Type)
JOHN W. PAYNE, M.D. | | | 22d. ADDRESS
VA HOSPITAL, FORT HOWARD, MARYLAND | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
5/31/67 | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cemetery | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | | |
| 24. FUNERAL DIRECTOR
J.A. Moran Funeral Home | | | 25. REGD. BY REGISTRAR
DATE MAY 31 1967 | | |
| | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

03441

03441

Maryland

Baltimore

Baltimore

120 Days

Fort Howard

2802 E. Baltimore Street

Veterans Administration Hospital

07

28

MAY

MAY

JOHN

WILLIAM

XX

72

9/2/71

White

Baltimore County, Maryland, U.S.A.

Steel

Machine Mail Holder

Flora's Father

William T. Walton

210-02-10-71 Clin. Sec. VA Hospital, Fort Howard, Md.

WM I

Yes

LESS THAN 10 DAYS

PNEUMONIA

YEARS

DIABETES MELLITUS

PERIPHERAL VASCULAR INSUFFICIENCY

January 19 67 2:20AM

May 28 67

XX

X 2/20/67

VA HOSPITAL, FORT HOWARD, MARYLAND

JOHN W. FAYNE, M.D.

3800 E. Baltimore, Md.
Baltimore, Maryland

Fort Howard General Hospital
Fort Howard, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06453

06442

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Baltimore 31 1/2 yrs.
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Robb Nursing Home | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 8310 Liberty Road
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
Anna | | First Middle Last
Waterman | | 4. DATE OF DEATH
Month Day Year
May 28 1967 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 8. DATE OF BIRTH
3-1-1872 | | 9. AGE (In years last birthday)
95 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min.
28 19 67 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Germany | | | |
| 11. BIRTHPLACE (County & State, or foreign country)
USA | | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 13. FATHER'S NAME
Henry Thune | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give year or dates of service)
NO | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Helen Marsh - 3521 Abbie Place
Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis
DUE TO (b) Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from May 15 1967 to May 28 1967 , that (I) (we) last saw the deceased alive on May 28 1967 , and that death occurred at 11:30 A.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Edmund Thompson | | | | 22b. ADDRESS
Ellsworth Armacost - 4600 Liberty Hgts, Ave. | | | |
| 22c. PHYSICIAN'S NAME (Type)
Edmund Thompson | | | | 22d. ADDRESS
Ellsworth Armacost - 4600 Liberty Hgts, Ave. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5-31-67 | | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge Cemetery | | | |
| 23d. LOCATION (City, town or county) (State)
Baltimore, Maryland | | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06454

CERTIFICATE OF DEATH

06443

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <i>Baltimore</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)
a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<i>Lutherville</i> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Lutherville</i> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<i>Burwood Ct.</i> | | | | d. STREET ADDRESS
<i>Burwood Ct.</i> | | | |
| 3. NAME OF DECEASED (Type or print)
First <i>James</i> Middle <i>Griffis</i> Last <i>Watkins</i> | | | | 4. DATE OF DEATH
Month <i>May</i> Day <i>6</i> Year <i>1967</i> | | | |
| 5. SEX
<i>Male</i> | | 6. COLOR OR RACE
<i>White</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>Jan. 1, 1919</i> | |
| 9. AGE (In years last birthday)
<i>48</i> yrs. | | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>President Top Crafts Inc.</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
<i>Smithville, Va.</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | | | | | |
| 13. FATHER'S NAME
<i>James R. Watkins</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Mattie Griffis</i> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<i>Yes</i> | | 16. SOCIAL SECURITY NO. (If yes give number or date of service)
<i>217-07-7916</i> | | 17. INFORMANT
<i>Mrs. Lavinia D. Watkins</i> Address <i>Lutherville, Md.</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>170X Carcinoma of lung</i>
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<i>6 months</i> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <i>19</i> | | 20d. INJURY OCCURRED
While et work <input type="checkbox"/> Not While et work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>1/3</i> <i>1967</i> , to <i>5/6</i> <i>1967</i> , that (I) was last saw the deceased alive on <i>5/5/67</i> <i>19</i> , and that death occurred at <i>11 A.M.</i> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>Milton B. Kirsh</i> | | M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<i>5/6/67</i> | |
| 22c. PHYSICIAN'S NAME (Type)
<i>Milton B. Kirsh, M.D.</i> | | 22d. ADDRESS
<i>4000 W. Northern Parkway - Baltimore, Md.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE THEREOF
<i>May 9, 1967</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Druid Ridge Cemetery</i> | | 23d. LOCATION (City, town or county) (State)
<i>Pikesville, Md.</i> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>J. F. Eline & Sons</i> | | | | ADDRESS
<i>Reisterstown, Md.</i> | | 25a. REC'D BY REGISTRAR
<i>MAY 9 1967</i> | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

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UNITED STATES OF AMERICA

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MAY 2 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06455

CERTIFICATE OF DEATH

06444

| | | | | | |
|--|--|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Balto. | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
2915 Ohio Ave. 21227 | | | d. STREET ADDRESS
2915 Ohio Ave. 21227 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
George W. Westphal | | | 4. DATE OF DEATH
Month Day Year
May 20 19 67 | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6/15/05 | 9. AGE (In years last birthday)
61 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Paper Cutter | | 10b. KIND OF BUSINESS OR INDUSTRY
Eickeberg Co. | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | |
| 13. FATHER'S NAME
Charles Westphal | | | 14. MOTHER'S MAIDEN NAME
Nellie Brandt | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WW II | | 16. SOCIAL SECURITY NO.
214-03-2055 | | 17. INFORMANT Address
Mr. Wilbur L. Polk 2915 Ohio Ave. 21227 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ac. Coronary occlusion
DUE TO A.S.C.V.D.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 10, 30 , 19 67 to 5, 17 , 19 67 , that (I) (we) last saw the deceased alive on 5, 17 , 19 67 and that death occurred at 6 P.M. from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
Justin Kudirka | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
5-22-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Justin Kudirka | | 22d. ADDRESS
2151 Wilkens Ave. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
5/24/67 | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard | | ADDRESS
4107 Wilkens Ave. 21229 | | 25a. REC'D BY REGISTRAR
MAY 23 1967 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06456

CERTIFICATE OF DEATH

06445

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills
c. LENGTH OF STAY IN TB 45yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 337 Rte 2 Deer Park Road | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills
d. STREET ADDRESS Box 337 Rt 2 Deer Park Road
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) Cecelia T. White | | 4. DATE OF DEATH
Month May Day 18 Year 1967 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 24, 1888
9. AGE (In years lost 79 yrs.)
IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/>
IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner-Florist | | 10b. KIND OF BUSINESS OR INDUSTRY Florist Business | |
| 11. BIRTHPLACE (County & State, or foreign country) Chicago, ILL. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 13. FATHER'S NAME (unknown) | | 14. MOTHER'S MAIDEN NAME Hattie Whitley | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 217-32-9782 | |
| 17. INFORMANT Mrs. Frieda Meginnis | | Box 337 Rt 2 Deer Pk Rd. Owings Mills Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac failure
DUE TO (b) metastatic carcinoma
DUE TO (c) Carcinoma rectum
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/> 19 <input type="checkbox"/> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 1962 to May 18, 1967 that (II) (we) last saw the deceased alive on May 18, 1967 , and that death occurred at 3:30 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE John Darrell | | 22b. DATE SIGNED 5-20-67 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. John J. Darrell | | 22d. ADDRESS 9017 Liberty Road Randallstown, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 5/22/67 | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | 23d. LOCATION (City or Town) (County) (State) Pikesville Balto MD. |
| 24. FUNERAL DIRECTOR Spring Byers Randallstown Md | | 25. REC'D BY REGISTRAR Charles Judge | |
| 25a. ADDRESS 8728 Liberty Rd | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |
| DATE MAY 22 1967 | | | |

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Box 207 - 208 2 East Park Road

Box 207 - 208 2 East Park Road

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May 18

May 18

White

T.

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Feb. 24, 1947

X

White

Female

1947

Chicago

Florida Engineer

Florida Engineer

White

(unknown)

Box 207 - 208 2 East Park Road

210-20-2782 Mrs. Florida Engineer

Chicago White Mt.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06457

CERTIFICATE OF DEATH

06446

| | | | | | | | |
|--|----------------------------------|---|--|--|---|--|---|
| 1. PLACE OF DEATH
o. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE MARYLAND b. COUNTY — | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | | c. LENGTH OF STAY IN 1b
15 DAYS | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | | | d. STREET ADDRESS
930 BROOKS LANE | | | |
| 3. NAME OF DECEASED (Type or print)
First VERNON Middle ANTHONY Last WHITTINGTON | | | | 4. DATE OF DEATH
Month MAY Day 27 Year 19 67 | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
AUGUST 27, 1920 | | 9. AGE (In years last birthday)
46 yrs. | IF UNDER 1 YEAR
Months — Days — | IF UNDER 24 HRS.
Hours — Min. — |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
KITCHEN HELPER | | | 10b. KIND OF BUSINESS OR INDUSTRY
SUN PAPERS | | 11. BIRTHPLACE (County & State, or foreign country)
BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
JAMES WHITTINGTON | | | | 14. MOTHER'S MAIDEN NAME
MARY WHITTINGTON | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
YES WW-11 | | | 16. SOCIAL SECURITY NO.
216 12 23 54 | | 17. INFORMANT
CLIN. REC., VAH, FT. HOWARD, MARYLAND | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC FAILURE
4344 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARDIAC DISEASE, UNKNOWN ETIOLOGY DUE TO
(c) — | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
YEARS
YEARS |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour — a.m. 19 p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 12 19 67 , to May 27 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 27 19 67 , and that death occurred at 12:00 P. M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>John Walter Payne</i> | | | 22b. DATE SIGNED
5/28/67 | | | 22c. PHYSICIAN'S NAME (Type)
JOHN WALTER PAYNE, M.D. | |
| 22d. ADDRESS
VAH, FORT HOWARD, MARYLAND | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5-31-67 | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | |
| 24. FUNERAL DIRECTOR
Morton & Dyett Funeral Home Baltimore, Maryland | | | 25a. REC'D BY REGISTRAR
MAY 31 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | |

62446

62446

INSTITUTE OF HEALTH

Division of Health and Human Resources

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CARDIAC FAILURE

CARDIAC DISEASE, UNKNOWN ETIOLOGY

YES

YES

IX

X 5/25/67

VAH, FORT HOWARD, H. DILLING

JOHN WALTER RAYNE, M.D.

Baltimore National Cemetery, Baltimore, Maryland

Burial

1801 Levens Street
Norton & Dyer Funeral Home, Baltimore, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06458

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06447

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Balto. Co.</u> MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Upperco</u>
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Dover Rd.</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Balto. Co.</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperco</u>
d. STREET ADDRESS <u>Dover Rd.</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Herman B. Wickline</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>18</u> Year <u>19 67</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>April 29, 1906</u> | |
| 9. AGE (In years last birthday) <u>61</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>1</u> Days <u>18</u> | | 11. IF UNDER 24 HRS.
Hours <u>19</u> Min. <u>67</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Mechanic</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Garage</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>West Va.</u> | |
| 13. FATHER'S NAME
<u>James W. Wickline</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Lenna Dameron</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>No.</u> (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>189-09-6639</u> | | 17. INFORMANT
<u>Mrs. May Wickline</u> <u>Dover Rd. Upperco, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Thrombotic Carcinoma</u>
1621 DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>Emphysema</u>
(a), stating the underlying cause last. DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. <u>19</u>
p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>February 1966</u> to <u>May 18, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 17, 1967</u> , and that death occurred at <u>10:45 AM</u> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Charles E. Wickline</u> M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>5-18-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) | | | | 22d. ADDRESS
<u>11904 Kintostown Rd Kintostown Md</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>5/21/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Pleasant Grove Cemetery</u> | | 23d. LOCATION (City, town or county) (State)
<u>Upperco Balto. Co. Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Tipton - Eline Funeral Home Hampstead, Md.</u> | | | | 25a. REC'D BY REGISTRAR
<u>MAY 22 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

12130

BOARD OF DIRECTORS

12130

MAY 8 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06459

CERTIFICATE OF DEATH

06448

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore - md. 21230</u> | |
| c. LENGTH OF STAY in 1b
<u>2 days</u> | | d. STREET ADDRESS
<u>1214 Patapasco Street.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Greater Balto. Medical Center.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
<u>George F Widmer</u> | | 4. DATE OF DEATH
Month Day Year
<u>May 29 1967</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>3-28-98</u> |
| 9. AGE (In years lost birthday)
<u>69</u> yrs. | | 10. UNDER 1 YEAR Months Days
11. UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired Paperitter Grinnell Co.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Buffalo, New York</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>U.S.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>George Widmer Sr.</u> | | 14. MOTHER'S MAIDEN NAME
<u>Burch Gertrude</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>no none</u> | | 16. SOCIAL SECURITY NO. <u>AB 215-09-7802</u> | |
| 17. INFORMANT
<u>Pl's. Chant</u> | | Address
<u>Laura Widmer-1214 Patapasco St.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>METASTATIC CA. RECTUM</u>
<u>154X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CACHEXIA</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5/27</u> , 19 <u>67</u> to <u>5/29</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>5/29</u> , 19 <u>67</u> , and that death occurred at <u>4:40</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Evelyn L. Ramos M.D.</u> | | | 22b. DATE SIGNED |
| 22c. PHYSICIAN'S NAME (Type) <u>EVELYN L. RAMOS, M.D.</u> | | | 22d. ADDRESS <u>G.B.M.C. Tolson 4</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>June 1/67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Meadowridge Cemetery</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Washington Blvd. Md.</u> |
| 24. FUNERAL DIRECTOR
<u>Krause Funeral Home 1216 S. Charles St.</u> | | 25a. REC'D BY REGISTRAR
<u>DATE MAY 31 1967</u> | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> |

1

1

METASTASIS OF RECTUM

Pt's Chart

George Wildman

Burch

Male white

3-28-98

George

Widmer

Location Baltimore Harbor

Baltimore

2-1-98

Baltimore - 1115 12 14

Belmont

Belmont

Belmont

ONCHOSIS

EVERY J. BAMES, M.D.
C. B. M. G. Jones

2/27

2/27

2/27

2/27

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06460

CERTIFICATE OF DEATH

07930

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
o. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE Maryland b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sparrows Point | |
| c. LENGTH OF STAY IN 1b
4yr3mth4dys | | d. STREET ADDRESS
2822 Large Farm Road | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Spring Grove State Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Cyrus Williams | | 4. DATE OF DEATH
Month Day Year
May 24 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan. 26, 1892 |
| 9. AGE (In years lost birthday)
75 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | 11. BIRTHPLACE (County & State, or foreign country)
South Carolina |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Henry Earl Williams | | 14. MOTHER'S MAIDEN NAME
Alice | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
Unknown | | 16. SOCIAL SECURITY NO.
213-07-6389 | |
| 17. INFORMANT
Records: Spring Grove State Hospital | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac failure
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) Arteriosclerotic cardiovascular disease
DUE TO
(c) Arteriosclerosis, generalized and severe | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that he (this hospital) attended the deceased from 2-20-63 , to May 24, 1967 , that he (we) last saw the deceased alive on May 24, 1967 , and that death occurred at 4:20 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Stella Wachslor | | 22b. DATE SIGNED
5-24-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Stella Wachslor, M.D. | | 22d. ADDRESS
Spring Grove State Hospital
Baltimore, Maryland 21228 | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF
May 29/67 | 23c. NAME OF CEMETERY OR CREMATORY
Int Calvary Cemetery | 23d. LOCATION (City or town) (County) (State) |
| 24. FUNERAL DIRECTOR
Robert E. Williams | | 25. REGISTRATION
1701-123456 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECORDS OF DEATH

Register

Columbiana

State of Ohio

County of Hamilton

Willard

Ohio

Jan. 24, 1902

Heath

John Heath

1857

1/20

John Heath

1857-1902

John Heath

1857-1902

1857-1902

1857-1902

John Heath

John Heath

1857-1902

1857-1902

John Heath

John Heath

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06461

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06449

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | |
| c. LENGTH OF STAY IN 1b
<u>404 mos.</u> | | d. STREET ADDRESS
<u>6531 Corkley Road 6</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>GREATER Baltimore Medical Center</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>William</u> Middle <u>FREDERICK</u> Last <u>WISSEL</u> | | 4. DATE OF DEATH
Month <u>MAY</u> Day <u>15</u> Year <u>1967</u> | |
| 5. SEX
<u>MALE</u> | 6. COLOR OR RACE
<u>CAUC</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>07-08-07</u> 59 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>COASTER OPERATOR</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Crown Cork & Seal Corp.</u> | 9. AGE (In years last birthday)
<u>59</u> yrs. |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>W H KIN / W H KIN / Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>William Frederick WISSEL</u> | | 14. MOTHER'S MAIDEN NAME
<u>WIEGAND Catherine</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>213-01-6707</u> | |
| 17. INFORMANT
<u>Mrs Evelyn B. Wissel</u> | | <u>6531 Corkley Road</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Wide spread tumor metastases</u>
<u>1538</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of colon</u>
DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>may 13</u> , 19 <u>67</u> , to <u>may 15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>may 15</u> , 19 <u>67</u> , and that death occurred at <u>12:30</u> AM, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Robert W. Smith</u> | | 22b. DATE SIGNED
<u>5-15-67</u> | 22c. PHYSICIAN'S NAME (Type)
<u>Robert W. Smith</u> |
| 22d. ADDRESS | | 22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>5-18-1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Zion Cemetery</u> | 23d. LOCATION (City, town or county) (State)
<u>Baltimore Co. Md.</u> |
| 24. FUNERAL DIRECTOR
<u>Lassahn Funeral Home</u> | | 25a. REC'D BY REGISTRAR
<u>MAY 17 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>J. Charles Judge</u> | | | |

05222

05182

X

Robert M. Smith
Handic of
and 13 of
2-12-03 X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06462

CERTIFICATE OF DEATH

06450

| | | | |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 21221
d. STREET ADDRESS
707 Myrth Avenue
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Anna Middle Marie Last Wolf | | 4. DATE OF DEATH
Month May Day 3 Year 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1-16-92 |
| 9. AGE (In years lost birthday)
75 yrs. | | 10. IF UNDER 1 YEAR
Months 7 Days 15 Hours 15 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY
Own home | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
JOHN SEITZ | | 14. MOTHER'S MAIDEN NAME
MARY BOEHM | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
UNK | | 16. SOCIAL SECURITY NO.
? | |
| 17. INFORMANT
HOSP. RECORDS | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Esophagus with Metastasis
150X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Hypertensive Cardiovascular disease in Failure. | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 19 o.m. <input type="checkbox"/> p.m. <input type="checkbox"/> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from April 10 , 19 67 , to May 3 , 19 67 , that (I) (we) last saw the deceased alive on May 3 , 19 67 , and that death occurred at 2:10AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Ramon P. Lopez | | 22b. DATE SIGNED
May 3, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Ramon P. Lopez | | 22d. ADDRESS
7620 York Road- Towson 21204, Maryland. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
5/6/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md | |
| 24. FUNERAL DIRECTOR
Connelly Law | | 25a. REC'D BY REGISTRAR
MAY 5 1967 | |
| ADDRESS
300 more | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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OFFICE OF THE SECRETARY

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MAY 5 1961

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06465

06451

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Dulaney-Towson Nursing & Convalescent Home | | d. STREET ADDRESS
5815 Willowton Ave....14 | |
| 3. NAME OF DECEASED
(Type or print) EDNA P. YOUNG | | 4. DATE OF DEATH
Month May Day 7 Year 1967 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 16, 1890. |
| 9. AGE (In years last birthday) yrs. 77 | | 10. IF UNDER 1 YEAR
Months 7 Days 19 | 11. IF UNDER 24 HRS.
Hours 14 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Clarence Pentz | | 14. MOTHER'S MAIDEN NAME
Laura C. Parsons | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
214-01-4369B | |
| 17. INFORMANT
Harry A. Young--5815 Willowton Ave....14 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of breast & Metastasis
DUE TO (b) 170X
DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH
3 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Arteriosclerosis, Coronary Artery Disease & Atherosclerosis | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May 3, 1967 , to May 7, 1967 , that (I) (we) last saw the deceased alive on May 3, 1967 , and that death occurred at 1:30 A.M. , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Dr. Thomas L. Worsley, Jr. | | 22b. DATE SIGNED
5/8/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. Thomas L. Worsley, Jr. | | 22d. ADDRESS
2900 Alameda...Balto., Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | 23b. DATE THEREOF
5/9/67. | |
| 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc.--Baltimore, Md....14 | | 25a. REC'D BY REGISTRAR
DATE MAY 8 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08121

CONTRACT OF SALE

08121

WITNESSETH THAT the within and foregoing is the true and correct copy of the original as the same appears from the records of the County of ...

IN

TO

FOR THE YEAR

IN

FOR THE YEAR

THE

RECORDS

RECORDS

James C. ...

James C. ...

James C. ...

James C. ...

James C. ...

James C. ...

James C. ...

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any part is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-4. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06463

06452

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|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
COUNTY M Baltimore
CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
STATE Md. COUNTY Baltimore
CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
7464 Berkshire Rd. # 21224 . | | d. STREET ADDRESS
7464 Berkshire Rd. # 21224 . | |
| 3. NAME OF DECEASED (Type or print)
JOSEPH ZAMENSKI | | 4. DATE OF DEATH
Month May Day 14 , Year 1967. | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
January 16, 1893 |
| 9. AGE (In years last birthday) 74 yrs. | | 10. IF UNDER 1 YEAR
Months 14 Days 14 | |
| 11. BIRTHPLACE (State or foreign country)
Pittsburgh, Pa. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Frank Zamenski | | 14. MOTHER'S MAIDEN NAME
Stanislawa Jaworowicz | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 705-03-5072 | |
| 17. INFORMANT
Mrs. Gertrude F. Smiley | | Address Same. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Occlusion
Conditions, if any, which gave rise to immediate cause (b) arterosclerotic Heart
(c), stating the underlying cause last. Disease
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Asthmatic Bronchitis | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month May Day 19 Year 1967
Hour a.m. p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Theodore C. Patterson | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
Theodore C. Patterson | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
5-17-67. | |
| 22c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 22d. LOCATION (City, town, or country) (State)
105 Main St. Dundalk, Md. # 21222. | |
| 23. FUNERAL DIRECTOR
Charles S. Zeiler | | 24a. REC'D BY REGISTRAR
MAY 17 1967 | |
| 24b. REGISTRAR'S SIGNATURE
Charles S. Zeiler | | 24c. ADDRESS
901 S. Conkling St. Baltimore, 21224, Md. | |

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George Washington

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06464

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06453

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Balto. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Randallstown | | c. LENGTH OF STAY IN 1b
8 hrs. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Chapel Hill Nursing Home | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Robert | | 4. DATE OF DEATH
Month May Day 2 Year 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 30, 1890 |
| 9. AGE (In years last birthday)
76 yrs. | | 10. IF UNDER 1 YEAR
Months 76 Days 76 Hours 76 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Collector | | 10b. KIND OF BUSINESS OR INDUSTRY
Gunther Brewery Co. | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
George H. Zittinger | | 14. MOTHER'S MAIDEN NAME
Caroline Hauser | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
216-05-4032 | |
| 17. INFORMANT
Mrs. Marie S. Zittinger | | Address Balto. 34 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Decompensated Arteriosclerotic C-V Disease
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Hremia
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
1 1/2 yrs.

2 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Emphysema- Mild Diabetes | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. none p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE D. D. Caples | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) D. D. Caples, M. D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 6 Hanover Rd., Randallstown, Md. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22. DATE SIGNED | | 5-3-67 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
5/5/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
LOUDON PARK CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE MD. | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc., 5305 Harford Rd., Balto. | | 25. REC'D BY REGISTRAR
MAY 5 1967 | |
| 25b. REGISTRAR'S SIGNATURE
John J. J... | | | |

10523

